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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	7/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/19 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/22/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

AMENDMENT NINE (9) AS ATTACHED. (07/14/20 mel)

AMENDMENT TEN (10) AS ATTACHED. (07/14/20 mel)

AMENDMENT ELEVEN (11) AS ATTACHED. (07/14/20 mel)

Jeremy Brunssen
42A61D4FE4D94B5...
DHHS DIVISION DIRECTOR

BUYER
MATERIEL ADMINISTRATOR
7/24/2020

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CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

J.S
BUYER INITIALS

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

AMENDMENT ELEVEN
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Glossary of Acronyms

HHA: Heritage Health Adult

B. Glossary of Terms

Basic Coverage: Provides benefits equivalent to the current state plan with the exception of dental services, vision services, and over the counter medications.

Benefit Tier: Individuals eligible in the Heritage Health Adult program will be eligible for coverage in one of two benefit tiers, the Nebraska Basic Alternative Benefit Plan, also known as the Basic benefit tier, and the Nebraska Prime Alternative Benefit Plan, also known as the Prime benefit tier.

Case Management: Case Management plan includes the Health Risk Screen which is the initial and ongoing screening to identify care needs of a beneficiary and identify any changes in health or social status.

Heritage Health Adult Expansion: Initiative 427, which expands Medicaid eligibility to able-bodied Nebraska residents, ages 19 to 64, whose income is at or below 138 percent of the federal poverty level.

Medically Frail: For an individual to be determined medically frail, he or she must have a documented medical condition attested to by a healthcare provider who is able to diagnose within the scope of his or her respective practice act and is licensed and in good standing within the state in which they practice, identified though analysis and evaluation of historical claims data performed by the MCO, or identified through information supplied by the Department, that falls into one or more of the following categories:

(i) A disabling mental disorder;
(ii) A chronic substance abuse disorder;
(iii) A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC 12 for the definition of activities of daily living for adults;
(iv) A disability determination based on Social Security criteria;
(v) A serious and complex medical condition; or

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(vi) Chronically homeless as defined by the United States Department of Housing and Urban Development.

Prime coverage: Provides benefits equivalent to the current state plan including dental services, vision services, and over-the-counter medications.

C. **Section IV.A.10 – Included Populations**
m. Members eligible for Heritage Health Adult (HHA) expansion

D. **Section IV.E.6.h. – Value-Added Services**
h. HHA members in the Basic Tier are not eligible for value-added services of dental, vision, or OTC medication.

E. **Section IV.F.5.f.xxxiv. – MEMBER SERVICES AND EDUCATION**
xxxiv. HHA Benefit Tier Requirements

F. **Section IV.K.4 – SUBCONTRACTING REQUIREMENTS**
4. MCOs must be able to communicate the eligibility of Prime vs. Basic membership with their subcontractors.

G. **Section IV.I.1.n – PROVIDER NETWORK REQUIREMENTS**
n. MCO must include in its contracts with its providers the requirement that Medically Frail attestation forms must be completed by the provider.

H. **Section IV.J.3.a.xxxi – PROVIDER SERVICES**
xxxi. HHA Benefit Tier Requirements

I. **Section IV.L.2.h. – CARE MANAGEMENT**
h. MCOs are required to implement the MLTC defined Health Risk Screening questions at a minimum.

J. **Section IV.R.2.k – SYSTEMS AND TECHNICAL REQUIREMENTS**
k. Transmit and receive the HHA Inbound MCE Member Data Response File

K. **Section IV.Z. HHA - Heritage Health Adult Expansion**

Effective October 1, 2020, all eligible HHA 19 to 64 year old members will receive integrated medical, behavioral health, and pharmacy benefits through the Heritage Health managed care program.

Members who meet the criteria for the Prime benefits package will receive vision and OTC benefits through their Heritage Health plan and dental benefits through the dental prepaid ambulatory health program (PAHP). Members who do not meet the criteria for Prime benefits will receive services equivalent to the current state plan with the exception of dental services, vision services, and over the counter medications.

All members newly eligible for Medicaid under the HHA program will receive the Basic benefits package.

HHA members will receive the Prime benefits package only if:

- They are medically frail; or
- They are age 19 or 20; or
- They are a pregnant woman eligible under expansion

A. Medically Frail

1. Any Heritage Health Adult (HHA) expansion group member may be evaluated by MLTC for medically frail status during any time of the member's enrollment.
2. MLTC is responsible for determining members as medically frail and providing final notification to the member of approval or denial of medically frail.
    a. MLTC will notify the MCO when medically frail is approved or denied.
3. The MCO may identify HHA members who may be medically frail using the following methods:
    a. The member self-identifies as medically frail to the MCO.
        i. The MCO must assist members who self-identify as medically frail with obtaining necessary documentation as required in MLTC Medically Frail Guidance policy. This also includes obtaining documentation collected by the member related to the medically frail condition.
    b. Information the MCO collects from the members Health Risk Screening which includes, but is not limited to, the MLTC defined required HRS questions.
        i. The MCO must assist members that the MCO has identified as potentially medically frail with obtaining necessary documentation as required in the MLTC Medically Frail Guidance policy. This also includes obtaining documentation collected by the member related to the medically frail condition.
    c. Performing periodic evaluation of the member's historical claims data including diagnosis information that is current and verified within a 12 month look back as defined in the medically frail guidance policy.
    d. Ongoing engagement with the member through care/case management as described in Section IV.L. Care Management.
        i. Enroll the HHA member that is determined to be medically frail in active care/case management as described in Section IV.L. Care Management
4. The MCO must submit a written notification letter to all members prior to or simultaneously with the MCO submitting a medically frail referral to MLTC. The written notification letter used by the MCO must include information members may use to contact the MCO, including telephone or e-mail specific to MCO staff responsible for medically frail referrals.
5. The MCO must provide medically frail referrals to MLTC according to the specifications included in the Medically Frail Guidance policy.
    a. The MCO must provide MLTC supporting documentation simultaneously with the submission of a medically frail referral

according to the specifications included in the Medically Frail Guidance policy.
   b. As requested by MLTC, the MCO must provide additional documentation to support a medically frail determination.
   c. MCO must use available data sources to support identification of potentially medically frail members (e.g. diagnosis retrieved from electronic health information available through NEHII).
6. MCOs must reassess members that MLTC has previously determined to be medically frail and refer members to MLTC prior to the end of the current determination according to the specifications included in the Medically Frail Guidance Document.
7. As requested by MLTC, the MCO must respond to MLTC requests for supporting documentation to support periodic audits.
8. MCO must transmit medically frail data to the Department on the HHA Inbound MCE Member Data Response file.

II. **Modifications:** The Parties hereto modify the following sections:

A. Glossary of Terms

Care Management: Care Management is the individualized beneficiary plan developed to address the physical health, behavioral health, or social determinant needs of a beneficiary. Care management is the strategies and methods utilized to stabilize and then improve the health of the beneficiary. Care management plans need to be responsive to beneficiary needs and include physical and behavioral interventions and care, along with social services supports.

Care Management Plans are:

- Ongoing and modified as needed to meet the changing needs of the patient
- Comprehensive
- Evidence-based
- Care coordination with multi-disciplinary care teams
  - At a minimum includes clinical and behavioral health services, psychosocial needs, referrals and care transition management
- Cost-effective and high-quality

Value-added services: Those services a MCO provides in addition to a service covered under this contract because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service. Value-added services of vision, dental, and OTC medications are not available to members in the HHA Basic Tier.

B. Section IV.E.8.a.xvi. – COVERED SERVICES AND BENEFITS

xvi. Vision Services. Vision services to the HHA Basic Tier members must be medically necessary based on a diagnosed condition or an emergency vision services.

C. Section IV.E.8.a.xxiii – COVERED SERVICES AND BENEFITS

xxxiii. Pharmacy Services. HHA members in the Basic Tier are excluded from OTC benefits, including those on the PDL.

D. Section IV.E.10. – COVERED SERVICES AND BENEFITS

10. Eye Care and Vision Services. As set forth in the Medicaid State Plan and applicable regulations, the MCO must provide to all members any medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments. Eye care and vision services are to be performed by a licensed ophthalmologist or optometrist, conforming to accepted methods of screening, and diagnosis and treatment. Vision services to the HHA Basic Tier members must be medically necessary based on a diagnosed condition or an emergency vision services.

H. Section IV.E.11.e – Pharmacy Services

e. The MCO must, at a minimum, cover the OTC drugs listed in the Medicaid State Plan, except for HHA members in the Basic Tier who are excluded from OTC benefits, including those on the PDL.

L. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and timeframes have been changed. The updated requirements are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This Amendment becomes part of the Contract. Except as set forth in this Amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/28/2020

WellCare of Nebraska

By: _____

Printed Name: Timothy J. Mayopoulos

Title: President

Date: 29 June 2020

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

By: Jeremy Brunssen
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

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

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Health Risk Screening Completion Report - 90 Day Eligible	Contains information related to eligible member completion of HRS within 90 days of enrollment	Monthly

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Health Risk Screening Completion Report - Annual Eligible	Contains information related to eligible member completion of HRS for annual enrollment	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Supplemental Member Care Report	Contains supplemental information related to member care and case management and member outreach.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC as follows: Dec. 15 (data from June 1-Nov 30), March 15th (data from Dec 1-Feb 28), June 15 (data from March 1-May 31)
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
Medication compliance report for Chronic Diseases and High Risk Therapeutic Classes	Medication compliance report for chronic disease medications and specific high-risk therapeutic classes as defined by MLTC Compliance measure aligns with HEDIS definition of compliance	Quarterly

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MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**

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Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually

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Attachment 38 – Revised Reporting Requirements

MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

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AMENDMENT TEN (10) AS ATTACHED. (07/14/20 mel)

DocuSigned by:
Jeremy Brunssen
42A61D4FE4D94B5...
DHHS DIVISION DIRECTOR

BUYER
MATERIEL ADMINISTRATOR
7/28/2020

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3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

JS
BUYER INITIALS

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

AMENDMENT TEN
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Attachment 11 – Rates

Rates for October 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

This Amendment becomes part of the Contract. Except as set form in this Amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: Douglas D Carlson

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/28/2020

WellCare of Nebraska

By: [signature]

Printed Name: TIMOTHY J. MEYERS

Title: President

Date: 16 June 2020

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

By: Jeremy Brunssen
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

WellCare – HH Rates – 10.1.2020

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
AABD 00-20 M&F	$1,288.31	$25.03	$1,313.34
AABD 21+ M&F	$1,767.88	$20.44	$1,788.32
AABD 21+ M&F-WWC	$5,362.59	$40.04	$5,402.63
CHIP M&F	$205.67	$3.50	$209.17
Family Under 1 M&F	$856.07	$18.89	$874.96
Family 01-05 M&F	$181.95	$3.72	$185.67
Family 06-20 F	$207.90	$3.20	$211.10
Family 06-20 M	$215.05	$2.98	$218.03
Family 21+ M&F	$568.25	$5.36	$573.61
Foster Care M&F	$569.57	$7.00	$576.57
Healthy Dual	$275.77	$0.00	$275.77
Dual LTC	$189.97	$0.00	$189.97
Non-Dual LTC	$3,678.89	$28.76	$3,707.65
Dual Waiver	$251.84	$0.00	$251.84
Non-Dual Waiver	$1,506.05	$15.22	$1,521.27
Katie Beckett 00-18 M&F	$13,624.39	$28.98	$13,653.37
599 CHIP - Cohort	$555.43	$3.96	$559.39
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,037.84	$68.41	$5,106.25
Refugee Resettlement	$287.36	$0.00	$287.36

Heritage Health Adult Rates (Rating Region 1)

Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
19-44 M - Prime	$371.85	$4.28	$376.13
19-44 F - Prime	$429.43	$4.95	$434.38
45-64 M&F - Prime	$1,078.97	$12.43	$1,091.40
21-44 M - Basic	$484.22	$5.58	$489.80
21-44 F - Basic	$533.76	$6.15	$539.91
45-64 M&F - Basic	$1,069.40	$12.32	$1,081.72
Medically Frail 19-44	$1,573.98	$17.45	$1,591.43
Medically Frail 45-64	$2,109.72	$23.38	$2,133.10

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WellCare – HH Rates – 10.1.2020

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
AABD 00-20 M&F	$1,348.61	$29.13	$1,377.74
AABD 21+ M&F	$2,062.98	$8.68	$2,071.66
AABD 21+ M&F-WWC	$6,536.79	$88.80	$6,625.59
CHIP M&F	$218.91	$1.29	$220.20
Family Under 1 M&F	$836.62	$10.81	$847.43
Family 01-05 M&F	$202.18	$1.15	$203.33
Family 06-20 F	$227.51	$0.78	$228.29
Family 06-20 M	$214.45	$0.72	$215.17
Family 21+ M&F	$644.38	$1.36	$645.74
Foster Care M&F	$494.13	$1.85	$495.98
Healthy Dual	$281.27	$0.00	$281.27
Dual LTC	$188.91	$0.00	$188.91
Non-Dual LTC	$2,142.70	$3.56	$2,146.26
Dual Waiver	$299.95	$0.00	$299.95
Non-Dual Waiver	$1,837.94	$10.16	$1,848.10
Katie Beckett 00-18 M&F	$13,624.39	$28.98	$13,653.37
599 CHIP - Cohort	$555.43	$3.96	$559.39
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,177.93	$2.90	$5,180.83
Refugee Resettlement	$287.36	$0.00	$287.36

Heritage Health Adult Rates (Rating Region 2)

Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Directed Payment**	**Payment Rate**
19-44 M - Prime	$431.20	$1.09	$432.29
19-44 F - Prime	$505.61	$1.28	$506.89
45-64 M&F - Prime	$1,243.94	$3.14	$1,247.08
21-44 M - Basic	$562.21	$1.42	$563.63
21-44 F - Basic	$629.98	$1.59	$631.57
45-64 M&F - Basic	$1,235.97	$3.12	$1,239.09
Medically Frail 19-44	$1,573.98	$17.45	$1,591.43
Medically Frail 45-64	$2,109.72	$23.38	$2,133.10

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	7/14/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/19 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/22/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

AMENDMENT NINE (9) AS ATTACHED. (07/14/20 mel)

DocuSigned by:
Jeremy Brunssen
42A61D4FE4D94B5...
DHHS DIVISION DIRECTOR

BUYER
7/28/2020
MATERIEL ADMINISTRATOR

DocuSign Envelope ID: F0EC1D8A-960D-4173-AF72-C5A870C70106

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)
VENDOR NUMBER: 1247761	

CONTRACT NUMBER
71164 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

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BUYER INITIALS

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AMENDMENT NINE
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Section IV.C.12.d – Audit Requirements

d. The MCO shall be subject to an audit of Managed Care Data operations and underlying security, privacy, and isolation controls, no more often than every three months, to ensure that the required controls for data isolation, access, and usage are operational. The audit will be conducted by a third party to be selected by MLTC and approved by the MCO. The MCO will provide open and complete access to the underlying systems. Any and all relevant and/or necessary documentation to support the audit must be provided by the MCO no less than ten (10) days ahead of the on-site audit. Said audit will be conducted at MCO's expense.

B. Section IV.E.3.f & g – Behavioral Health Parity

f. The MCO may not impose an annual dollar limit on mental health or substance use disorder benefits per 42 CFR 438.905 (b). Any financial, quantitative or non-qualitative limits in force, are applied consistently for medical/surgical & mental health/SUD benefits per 42 CRF 438.910.

g. MCO may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO, PIHP, or PAHP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards.

C. Section IV.R.9.I -

I. The MCO must adhere to the following Data Protection Requirements:

i. Medicaid data must be maintained and stored solely by the servicing MCO, except as in (ii) below. The MCO may not use a subcontractor or other entity owned, controlled, and/or operated by any other MCO operating within the State of Nebraska or any other state to store, maintain, utilize, share, or access any Medicaid data.

ii. During a transition period, as defined by IV.X., resulting from a merger, reorganization and/or change of ownership as defined by IV.C.11, the MCO must submit a Data Use Agreement to MLTC no later than thirty (30) days prior to the start of the transition regarding temporary dual-retention of data during the transition.

iii. Medicaid data previously stored, maintained, utilized, shared, or accessed by a MCO must be destroyed and/or rendered completely and totally inaccessible contemporaneously upon completion of a merger, reorganization, and/or change of ownership per the terms of Section IV.C.11 (Merger, Reorganization, and Change of Ownership).

D. Section IV.V.2.j

j. Data Breach

i. Should the MCO fail to protect Medicaid data in accordance with the terms of this contract or any applicable law, MTLC may assess damages of $10,000 per calendar day for each day the MCO remains in breach.

II. **MODIFICATIONS:** The Parties hereto modify the following sections:

A. Section IV.X.2.a - Transition Period

a. The transition period for the contract begins on contract award and ends 90 days after the contract start date for new contracts. The transition period for a contract resulting from a merger, reorganization, or change in ownership of an existing contract begins at the date of close of said the merger, reorganization, or change of ownership, and ends 180 days thereafter, with optional 90-day extension periods available upon request in writing by the MCO no less than ten (10) days prior to the end of each period, and upon approval by MLTC. During the transition period the MCO must implement the requirements of the contract and collaborate with MLTC to facilitate a seamless transition between MCOs, providers and programs in order to prevent an interruption of services and to ensure continuity of care for members.

With the exception of transplants, for which all previous authorizations will be honored, MCOs will honor, regardless of provider participation network status, previous authorizations for the lesser of:

i. 90 days from implementation;
ii. The end date on the authorization from the previous entity; or
iv. A new decision by the plan with consultation from the provider if determined on the medical necessity of the service.

B. Section IV.C.11 - Merger, Reorganization, and Change of Ownership

a. The MCO must submit notification to MLTC of a merger, reorganization, or change of ownership prior to its proposed effective date. The MCO must also submit a detailed merger, reorganization, or transition plan to MLTC for review prior to the effective date of the proposed merger, reorganization, or change of ownership. The purpose of the transition plan's review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the MCO must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership. This plan must be approved by MLTC prior to any merger, reorganization, or change of ownership. MLTC will not permit one organization to own or manage more than one contract within the same program.

b. Upon a merger, reorganization, or change of ownership of any MCO, MLTC may offer open enrollment period of no more than ninety (90) calendar days to all Medicaid members. During this period of open enrollment, each member may change to another MCO for any reason. Each MCO must notify its respective members of the open enrollment period and their rights therein.

C. Section IV.C.8 – Participation in the Nebraska Health Information Initiative

The MCO is required to enter into a participation agreement with the Nebraska Health Information Initiative (NeHII). NeHII is a non-profit organization that includes health care providers, payers, and the State. NeHII's purpose is to achieve health care transformation through the creation of a secure, web-based health information exchange to serve the State. More information on NeHII can be found at: www.nehii.org.

III. MODIFICATIONS: The Parties hereto modify the following sections, effective sixty (60) days after execution of this amendment:

A. Section IV.B.3.f.iii – Auto-Assignment Algorithm

iii. MLTC reserves the right to remove the MCO from the auto-assignment round robin process for any quarter, beginning with the 4th Quarter, 2020, but members can continue to pro-actively select that plan.

This Amendment becomes part of the contract. Except as set form in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/28/2020

WellCare of Nebraska

By: _____

Printed Name: TIMOTHY J. MEYERS

Title: President

Date: 13 July 2020

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

By: Jeremy Brunssen
42A61D4FE4D94B5...

Name: Jeremy Brunssen

Title: Interim Director

Date: 7/22/2020 | 13:41:23 CDT

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	03/03/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/19 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/22/19 ml)

AMENDMENT EIGHT (8) AS ATTACHED. (03/03/20 mel)

DHHS DIVISION DIRECTOR

3/4/20
BUYER

3-4-2020
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
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Lincoln, Nebraska 68508

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PAGE	ORDER DATE
2 of 2	03/03/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 1247761

CONTRACT NUMBER
71164 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
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2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT EIGHT
Contract 71164 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. IV.N.9.c; i; ii; iii; and iv

c. Per section 1004 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)* consistent with section 1902(oo)(1)(A)(ii) of the Social Security Act, MCO is required to operate a DUR program and implement provisions in the DUR program, effective October 1, 2019. The MCO DUR program must have in place:

i. prospective safety edits and a claims review automated process for subsequent opioid fills (refills) when in excess of any limitation (duplicate fills, early fills, and drug quantity limitations) that may be specified by the State and retrospective safety edits and a claims review automated process for any fills in excess of the maximum MME dose limitation identified by the state.

ii. process for retrospective automated claims review (as specified by the state) that monitors concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. Permitted exclusions from the above safety edits and claims review requirements to not apply to beneficiaries receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; or other individuals the state elects to treat as exempted from such requirements

iii. program to monitor and manage appropriate use of antipsychotic medications by children not more than the age of 18 and children in foster care.

iv. process as defined by the state that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled. Process may include lock in programs and prescription drug monitoring programs.

B. Section IV.P.14; i; ii; a; i; ii; and iii; b and c – Reinvestment Accounts

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

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

ii. A reinvestment account, for the purpose of holding funds pursuant to Neb. Rev. Stat. §71-831 subject to reinvestment.

a. Both the holding and reinvestment distribution accounts must:

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

ii. Have no risk-bearing investments.

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

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

c. The MCO will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements outlined in Section IV.T Reporting and Deliverables of this RFP.

C. Attachment 42 - High Risk Drug Pool Risk Corridor

The high cost drug pool risk corridors are set forth in Attachment 42 attached hereto and made a part hereof.

II. **Modifications:** The Parties hereto modify the following sections:

A. Section IV.P.2.e.xvii

xvii. Refugee Medical Assistance Program (RMAP)

B. Section IV.P.2.i – Capitation Rate Determination Process

i. Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR 438.6(c), and 42 CFR 457.1203(a). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

C. Section IV.P.9.c

c. This calculation must be completed within eleven (11) months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipt under the risk corridor will be incorporated in the MLR calculation. This methodology is consistent with the Final Rule published by CMS.

D. Section IV.P.12.d

d. To ensure compliance with state law, MLTC will calculate the administrative expense rate within eleven (11) months of the end of each contract year.

E. Section IV.P.17 – High Cost Drug Pool Risk Corridor

Beginning with the CY19 contract period MLTC implemented a high cost drug pool as part of the Heritage Health program. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). The CY19 high-cost drug pool was considered budget-neutral from the State and CMS' perspective. However, as a result of continued uncertainty regarding emerging high cost drugs coming into the market, MLTC is implementing a risk corridor around the high-cost drug pool effective January 1, 2020, as set forth in Attachment 42 – High Cost Drug Pool Risk Corridor.

F. Attachment 11 – Rates

Rates for January 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

G. Attachment 14 – Quality Performance Program Measures-Contract Year Four

The Quality Performance Program measures have been revised for the time period January 1, 2020, through December 31, 2020, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

H. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and timeframes have been changed. The updated requirements are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 3-4-2020

WellCare of Nebraska

By: _____

Printed Name: Timothy J. Meyers

Title: President, WellCare of Nebraska

Date: February 28, 2020

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

By: _____

Name: Matthew Van Patton

Title: Director

Date: March 4, 2020

Attachment 42
High Cost Drug Pool Risk Corridor

Beginning with the CY19 contract period the State has implemented a high cost drug pool as part of the Heritage Health program. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). The CY19 high-cost drug pool was considered budget-neutral from the State and CMS' perspective. However, as a result of continued uncertainty regarding emerging high cost drugs coming into the market, the State has decided to include a risk corridor around the high-cost drug pool in CY20. Detail surrounding the high-cost drug risk corridor below.

Drug Identification Criteria
High-cost drug experience has been identified within the CY18 base data using a cost-based approach. Ten digit Generic Product Indicators (GPIs), and injectable codes on the CY18 fee schedule that have an average cost of $10,000 PMPM have been classified as high-cost. This high-cost drug pool will only be applicable to the non-dual populations. The following Heritage Health rating cohorts will be exempt: Healthy Dual, Dual LTC, and Dual Waiver.

The following steps have been taken to identify the GPIs or injectables that meet the high-cost criteria:
1. Utilizers of each GPI or injectable were identified, along with all associated member months for these utilizers.
2. The total dollars paid, and total member months for drug utilizers were summarized to determine an average "utilizer" PMPM for each GPI and injectable within the CY18 data.
3. Each GPI or injectable with an average "utilizer" PMPM of $10,000 or greater meet the criteria for the high cost pharmacy risk pool within the base data.

For example: there are 10 members who utilize a particular GPI in CY18. These 10 members have a combined 90 member months through CY18. The total expenditures for this GPI are $900,000, resulting in an average PMPM of $10,000. All expenditures associated with this GPI would now be included in the development of the high-cost drug pool.

Establish Benchmarks
Upon identification of the relevant GPIs and injectables, the total spend associated with these drugs are summarized to arrive at a specific high cost drug PMPM by COA and Rating Region. These amounts are then projected forward to the CY20 contract period. A sample of the high-cost drug pool cost projection is show below:

COA	Total COA MMs	High Cost GPI PMPM	High Cost Injectable Code PMPM	Total High Cost PMPM (GPI+J Code)	Illustrative Projection Factor	Projected to CY20
1	50,000	*$0.00*	*$0.00*	$0.00	-	$0.00
2	150,000	*$8.00*	*$2.00*	$10.00	1.15	$11.50
3	250,000	*$15.00*	*$5.00*	$20.00	1.15	$23.00

Once COA and Regional PMPM projections are established, these PMPMs are converted to MCO-specific PMPMs. MCO-specific PMPMs are calculated using the CDPS+Rx prospective risk score applicable to the CY20 Heritage Health capitation rates.

		MCO A		MCO B	
COA	**Statewide Projected to CY20**	**Risk Score**	**MCO-Specific PMPM**	**Risk Score**	**MCO-Specific PMPM**
1	$0.00	1.00	$0.00	1.00	$0.00
2	$11.50	1.10	$12.65	0.90	$10.35
3	$23.00	0.95	$21.85	1.05	$24.15

Experience Period Reconciliation

Once the CY20 contract period ends, a reconciliation will occur between MCOs to the extent that the distribution of high cost drugs between MCOs is different than the distribution projected by the rate development process.

A total pool of dollars will be calculated after the end of the CY20 contract period. This pool will be calculated based on the total CY20 member months and the MCO-specific PMPMs described in the "Establish Benchmarks" section above. Once this pool is established, dollars may be added to or subtracted from the pool, as a result of the risk corridor that is in place for CY20.

In order to determine the CY20 actual expenditures that will be compared to the high-cost drug pool, high cost GPIs and injectables relevant to CY20 will be determined. Due to the nature of new drugs coming onto the market over time, it is possible that drugs that exist in CY20 were not present in the CY18 base data period. Therefore, a separate identification of drugs with an average PMPM of $10,000 in the CY20 contract period will be completed. This will be completed in a manner consistent with the approach described in the "High Cost Drug Identification Criteria" section above, with the exception being that the membership and claims data will be based on CY20 experience, and a standardized unit cost will be applied to NDCs underlying each GPI identified. Once this identification process is completed, the total experience for the GPIs and injectables that meet the criteria in CY20 will comprise the experience to be compared to the high-cost drug pool.

Prior to determining dollar transfers between MCOs, the CY20 experience for drugs that meet the high cost criteria will be evaluated against the risk corridor. The risk corridor bands are noted below:

Corridor Bands		**State/Fed and MCO Share**	
Low	**High**	**State/Fed Share**	**MCO Share**
<=85%	85%	100%	0%
85%	90%	75%	25%
90%	95%	50%	50%
95%	100%	0%	100%
100%	105%	0%	100%
105%	110%	50%	50%

110%	115%	75%	25%
115%	>=115%	100%	0%

If the program-wide experience for high cost drugs exceeds the original pool enough to warrant a State/Fed share of the excess expenditures, new dollars will be added to the pool in addition to the capitation rates. Likewise, if the experience is far enough below the original pool to warrant State/Fed savings, then dollars will be removed and MCOs will collectively pay dollars back to the State/Fed.

Once the risk corridor is calculated, any additions or reductions to the pool are made as necessary. A dollar transfer will then occur to the extent that an MCO's total contribution to the statewide pool is proportionally different than its actual CY20 experience as compared to the statewide CY20 actual experience. For example: an MCO's CY20 member months multiplied by its MCO-Specific PMPMs contributes 30% of the high cost drug pool but its CY20 expenditures for high cost drugs reflects 35% of the statewide CY20 expenditures. In this scenario, the MCO would receive a payment of 5% (35% - 30%) of the total high-cost drug pool. Conversely, either one or two of the other MCOs would have to pay out the equivalent of the 5%.

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,156.90	$25.03	$1,181.93
AABD 21+ M&F	$1,587.55	$20.44	$1,607.99
AABD 21+ M&F-WWC	$4,815.60	$40.04	$4,855.64
CHIP M&F	$184.69	$3.50	$188.19
Family Under 1 M&F	$768.75	$18.89	$787.64
Family 01-05 M&F	$163.39	$3.72	$167.11
Family 06-20 F	$186.69	$3.20	$189.89
Family 06-20 M	$193.11	$2.98	$196.09
Family 21+ M&F	$510.29	$5.36	$515.65
Foster Care M&F	$511.47	$7.00	$518.47
Healthy Dual	$247.64	$0.00	$247.64
Dual LTC	$170.59	$0.00	$170.59
Non-Dual LTC	$3,303.64	$28.76	$3,332.40
Dual Waiver	$226.15	$0.00	$226.15
Non-Dual Waiver	$1,352.43	$15.22	$1,367.65
Katie Beckett 00-18 M&F	$12,234.70	$28.98	$12,263.68
599 CHIP - Cohort	$498.77	$3.96	$502.73
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,037.84	$68.41	$5,106.25
Refugee Resettlement	$287.36	$0.00	$287.36

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,211.05	$29.13	$1,240.18
AABD 21+ M&F	$1,852.56	$8.68	$1,861.24
AABD 21+ M&F-WWC	$5,870.04	$88.80	$5,958.84
CHIP M&F	$196.58	$1.29	$197.87
Family Under 1 M&F	$751.28	$10.81	$762.09
Family 01-05 M&F	$181.55	$1.15	$182.70
Family 06-20 F	$204.30	$0.78	$205.08
Family 06-20 M	$192.58	$0.72	$193.30
Family 21+ M&F	$578.65	$1.36	$580.01
Foster Care M&F	$443.73	$1.85	$445.58
Healthy Dual	$252.58	$0.00	$252.58
Dual LTC	$169.64	$0.00	$169.64
Non-Dual LTC	$1,924.14	$3.56	$1,927.70
Dual Waiver	$269.36	$0.00	$269.36
Non-Dual Waiver	$1,650.47	$10.16	$1,660.63
Katie Beckett 00-18 M&F	$12,234.70	$28.98	$12,263.68
599 CHIP - Cohort	$498.77	$3.96	$502.73
599 CHIP - Supplemental	$4,606.53	$28.38	$4,634.91
Maternity	$5,177.93	$2.90	$5,180.83
Refugee Resettlement	$287.36	$0.00	$287.36

Attachment 14
Quality Performance Program Measures – Contract Year Four

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	5%
Encounter Acceptance Rate: Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	15%
Appeal Resolution Timeliness: MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children (LSC): Percentage of children two (2) years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	69%	10%
Well-Child Visits in the First 15 Months of Life (W15): Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits. • One (1) well-child visit. • Two (2) well-child visits. • Three (3) well-child visits. • Four (4) well-child visits. • Five (5) well-child visits. • Six (6) or more well-child visits.	69%	10%
Adolescent Well-Care Visits (AWC): Percentage of enrolled members 12-21 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	57%	10%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34): Percentage of members three (3) to six (6) years of age who had one (1) or more well-child visits with a PCP during the measurement year.	71%	10%

at least three (3) follow-up visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • *Initiation Phase. P*ercentage of members six (6) to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one (1) follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *Continuation and Maintenance (C&M) Phase*. Percentage of members six (6) to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two (2) follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Note: State pharmacy file format change may impact validation	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH): Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/CHIP.	Monitoring Metric Only 2018 CMS Median 80.6%	NA
Antidepressant Medication Management (AMM): Percentage of members 18 years of age and older treated with antidepressant medication, had a diagnosis of major depression and remained on antidepressant medication treatment. Two rates are reported: 1. *Effective Acute Phase Treatment*. Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. *Effective Continuation Phase Treatment*. Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Monitoring Metric Only Note: State pharmacy file format change may impact validation	NA

Plans may use whichever reporting methodology that they wish but must notify the state on submission. State may request supporting documentation for metrics, including but not limited to, claims extracts, denominator member list, supplemental information used in calculation, etc. If the plan does not supply the requested documentation, the measure target will be held to have not been met.

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

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

Ad Hoc Deliverables	Description	Due Date
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly

Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC as follows: Dec. 15 (data from June 1-Nov 30), March 15th (data from Dec 1-Feb 28), June 15 (data from March 1-May 31)
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly

NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31

MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually by November 1
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually

Attachment 38 – Revised Reporting Requirements

Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	07/22/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE (1) AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/19 ml)

AMENDMENT SEVEN (7) AS ATTACHED. (7/22/19 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE	392,451,761.0000	$	1.0000	392,451,761.00

DHHS DIVISION DIRECTOR

7/24/19

7/25/19
BUYER

7/29/19
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	07/22/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)
VENDOR NUMBER: 1247761	

CONTRACT NUMBER
71164 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT TERM YEAR 1				
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT SEVEN
Contract 71164 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **REMOVALS:** The following section is hereby removed:

A. Attachment 7 – Performance Measures

B. IV.I.14.i

II. **ADDITIONS:** The following sections are hereby added effective November 1, 2019:

A. Section IV.S.4.a.vi – Drug Claims Processing

vi. MLTC prohibits "spread pricing" defined as any amount charged or claimed by a PBM to an MCO that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

C. Section IV.E.22.f.ix – Medical Services for Special Populations

x. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly.

III. **Modifications:** The Parties hereto modify the following sections:

A. Section IV.B.6.b – MCO Changes

b. After the initial 90 calendar day period, Medicaid members will be locked in to their MCO selection until the next annual open enrollment period. The annual open enrollment period will take place November 1 through December 31 each year of the contract.

B. Section IV.D.3.k – Additional Required Staff

k. Non-Emergency Medical Transportation (NEMT) Network Coordinator. Responsible for receiving and processing provider inquiries and complaints, investigating provider complaints, and referring complaints to the Public Service Commission (PSC) for transportation providers governed by the PSC. The NEMT Network Coordinator is also responsible for resolving provider issues to include but not limited to payment delays. This position must be available to meet personally with transportation providers but is not required to be located in Nebraska.

C. Section IV.E.6.a – Value Added Services

a. As permitted under 42 CFR 438.3(e), and to the extent consistent with provisions of State law, the MCO may, in its discretion, offer expanded services and benefits to enrollees in addition to those benefits and services specified in this section of the RFP.

D. Attachment 11 – Rates

July 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

E. Attachment 38 – Revised Reporting Requirements

The Reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Gordon

Title: Materiel Administrator

Date: 7/29/19

WellCare of Nebraska

By: _____

Printed Name: Timothy J. Meyers

Title: President, WellCare of Nebraska

Date: 17 July 2019

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

By: _____

Name: Matthew Van Patton

Title: Director

Date: 24 July 2019

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,082.46	$26.78	$1,109.24
AABD 21+ M&F	$1,566.01	$26.14	$1,592.15
AABD 21+ M&F-WWC	$3,385.08	$153.92	$3,539.01
CHIP M&F	$174.89	$2.04	$176.93
Family Under 1 M&F	$758.35	$12.03	$770.38
Family 01-05 M&F	$149.86	$2.45	$152.30
Family 06-20 F	$175.03	$2.41	$177.44
Family 06-20 M	$190.30	$2.09	$192.39
Family 21+ M&F	$456.15	$8.37	$464.52
Foster Care M&F	$519.74	$6.25	$525.99
Healthy Dual	$230.10	$2.60	$232.70
Dual LTC	$224.78	$0.53	$225.31
Non-Dual LTC	$3,373.90	$32.44	$3,406.34
Dual Waiver	$246.91	$1.25	$248.16
Non-Dual Waiver	$1,404.58	$16.11	$1,420.69
Katie Beckett 00-18 M&F	$11,549.17	$35.95	$11,585.11
599 CHIP - Cohort	$438.11	$6.60	$444.71
599 CHIP - Supplemental	$4,754.16	$50.30	$4,804.46
Maternity	$5,036.12	$44.13	$5,080.24
Refugee Resettlement	$263.16	$0.00	$263.16

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,408.55	$7.52	$1,416.08
AABD 21+ M&F	$1,712.01	$8.96	$1,720.97
AABD 21+ M&F-WWC	$3,588.88	$61.20	$3,650.08
CHIP M&F	$170.14	$0.92	$171.05
Family Under 1 M&F	$747.73	$7.69	$755.42
Family 01-05 M&F	$151.52	$0.74	$152.25
Family 06-20 F	$194.99	$0.75	$195.74
Family 06-20 M	$197.96	$0.55	$198.51
Family 21+ M&F	$543.77	$2.64	$546.41
Foster Care M&F	$556.05	$2.59	$558.64
Healthy Dual	$236.02	$0.33	$236.35
Dual LTC	$207.03	$0.09	$207.11
Non-Dual LTC	$2,075.10	$1.40	$2,076.50
Dual Waiver	$277.32	$0.12	$277.44
Non-Dual Waiver	$1,538.29	$5.10	$1,543.39
Katie Beckett 00-18 M&F	$11,549.17	$35.95	$11,585.11
599 CHIP - Cohort	$438.11	$6.60	$444.71
599 CHIP - Supplemental	$4,754.16	$50.30	$4,804.46
Maternity	$5,092.04	$8.69	$5,100.73
Refugee Resettlement	$263.16	$0.00	$263.16

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

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

Ad Hoc Deliverables	Description	Due Date
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly

Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature by MLTC on Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit the data for these reports to MLTC as follows: Dec 15 (data from July 1 – Nov 30), March 15th (data from Dec 1 –Feb 28), June 15 (data from March 1 – May 31).
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly

MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to	June 30 and December 31

	the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
MLTC Reporting Database: CAHPS -- Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1

Attachment 38 – Revised Reporting Requirements

PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	01/09/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

AMENDMENT SIX (6) AS ATTACHED. (1/9/19 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00

DHHS DIVISION DIRECTOR

2/20/19 2.25.19
BUYER
2/26/19
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	01/09/19
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 1247761

CONTRACT NUMBER
71164 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT SIX
Contract 71164 04
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 04 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **REMOVALS:** The following section is hereby removed effective January 1, 2019:

A. **Glossary of Term:**
Reinvestment Account.

II. **REMOVALS:** The following sections are hereby removed effective July 1, 2019:

Section IV.E.29.h

Section IV.P.14

III. **ADDITIONS:** The following sections are hereby added effective July 1, 2019:

A. **Glossary of Terms**

Accompanying Adults: A legally responsible adult/guardian, or an adult selected by the legally responsible adult, to accompany a minor to a Medicaid coverable service.

Common Carrier: Any commercial provider who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

Consecutive Appointments: Appointments beginning, or scheduled to begin, within thirty (30) minutes of the last completed appointment.

Escort/Attendant Provider: A paid or unpaid individual or caregiver accompanying a program eligible member who is physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Nebraska Medicaid coverable service. The escort/attendant provider may drive or utilize transportation services with the program eligible member.

Exempt Provider: An individual or entity providing transportation services exempted from Public Service Commission licensure by law (Neb. Rev. Stat. § 75-303).

Individual Provider: A person who is not in the business of providing transportation for hire; for example, a friend, neighbor, or non-legally responsible relative, exempted from Public Service Commission (PSC) licensure by law (Neb. Rev. Stat. § 75-303.01).

Public Transportation: A fixed or non-fixed route public transit system regulated as such with the Nebraska Department of Transportation (NDOT) (See Neb. Rev. Stat. § 13-1203).

B. Section IV.A.10 – Included Populations

j. Members eligible for the Refugee Medical Assistance Program (RMAP).

k. Members eligible for the State Disability Program-Medical (SDP Medical).

l. Members with continuous eligibility that have a share of cost.

C. Section IV.D.3 – Additional Required Staff

k. Non-Emergency Medical Transportation (NMET) Network Coordinator. Responsible for receiving and processing provider inquiries and complaints, investigating provider complaints, and referring complaints to the Public Service Commission (PSC) for transportation providers governed by the PSC. The NEMT Network Coordinator is also responsible for resolving provider issues to include but not limited to payment delays. This position must be available to meet personally with transportation providers but is not required to be located in Nebraska.

IV. **Modifications:** The Parties hereto modify the following sections effective January 1, 2019:

A. Glossary of Terms

Hold-back account: The portion of the MCO's revenue that the MCO must reserve in the holding account and may potentially earn based upon MLTC's determination of the MCO's results on identified performance measures.

B. Section IV.J

3. Provider Handbook

xix. Paper and electronic claims submission protocols and standards, including instructions and all information necessary for a claim, in accordance with 42 CFR 447.45, along with samples of claims.

C. Section IV.M

6. Quality Performance Measurement and Evaluation

a. The MCO must report on CMS Adult Core, Child Core, CAHPS, and HEDIS measures, as well as additional performance measures as determined by MLTC. Measures may be removed or added at will by MLTC, and MCOs will be given a 60 day period in which to implement additional measure requirements. MCOs will report using the most

current version, specification, or manual that is available prior to required reporting deadlines, as is related to the given measure set. MCOs may request exemption from reporting specific measures within respective sets due to inability to report, subject to MLTC approval, within a MLTC designated schedule.

D. Section IV.P

5. Supplemental Delivery Payments

g. Supplemental payment for deliveries will be to reimburse the MCO for the expenses incurred between the date of admission and the date of discharge of a delivery event.

9. Risk Corridor

d. If the calculation produces a profit above the indicated amount, the MCO must ensure that the surplus is returned to MLTC, within 30 days of written notification of the final surplus amount from MLTC.

e. The MCO must provide a full financial statement and additional data, as requested to MLTC and its actuary to support the calculation. MLTC will reimburse the Federal share of the forfeited funds to CMS and retain the state share for reinvestment pursuant to Neb. Rev. Stat. §71-831.

10. MLTC Quality Performance Program

g. The MCO must return unearned (forfeited) hold-back funds to MLTC.

E. Section IV.Q

9. Reimbursement to FQHCs and RHCs

g. The MCO may stipulate that reimbursement is contingent on receiving a claim, in accordance with 42 CFR 447.45, and all medical information required to update the member's medical record.

F. Section IV.S

3. Claims Processing

ii. In accordance with 42 CFR 447.45, process and pay or deny, as appropriate, a minimum of 90% of all claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.

iii. In accordance with 42 CFR 447.45, process and pay or deny, as appropriate, a minimum of 99% of all claims for

medical services provided to members within 60 calendar days of the date of receipt.

b. For Pharmacy providers, in accordance with 42 CFR 447.45, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all claims are paid within 14 calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.

d. Pended Claims
In accordance with 42 CFR 447.45, if a claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

5. Payments to Providers

e. The MCO must pay providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable claim, in accordance with 42 CFR 447.45, remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

7. Paid Claims Sampling

b. The MCO must stratify the sample group by dollar figure amounts in a representative manner. To the extent that the MCO or MLTC considers a particular pool to warrant closer scrutiny, the MCO may oversample this group. The paid claims sample should be a minimum of 2% of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 38 - Revised Reporting Requirements. Stratifications of groups should be done by the following dollar amounts: $0 – $999.99, $1,000 - $9,999.99, $10,000 - $49,999.99, $50,000 or greater.

10. Encounter Data

c. The MCO must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The MCO must comply with industry-accepted claim standards, in accordance with 42 CFR 447.45, for all encounter data, including submission of complete and accurate data for all fields

required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

u. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all claims, in accordance with 42 CFR 447.45, adjudicated and/or adjusted by the MCO.

G. Attachment 11 – Rates

January 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

H. Attachment 14 – Quality Performance Program Measures-Contract Year Two

The Quality Performance Program measures have been revised for the time period January 1, 2019, through December 31, 2019, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

V. Modifications: The Parties hereto modify the following sections effective July 1, 2019:

A. Section IV. A.11 – Excluded Populations

b. Beneficiaries who have excess income or are required to pay a premium, and are intermittently eligible.

B. Section IV.E. – Covered Services and Benefits

8. Core Benefits and Services

The following services represent a minimum benefit package that the MCO must provide to its members:

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.

iii. Ambulatory surgical center (ASC) services.

iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.

v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

vi. Services provided in Indian Health Service (IHS) facilities.

vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.

viii. Radiology services.

ix. Health Check (EPSDT) services.

x. Home health services.

xi. Private duty nursing services.

xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).

xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.

xiv. Podiatry services.

xv. Chiropractic services.

xvi. Vision services.

xvii. Free standing birth center services.

xviii. Hospice services, except when provided in a nursing facility.

xix. Skilled/rehabilitative and transitional nursing facility services.

xx. Ambulance services.

xxi. Non-emergency medical transportation.

xxii. Transplant services.

xxiii. Pharmacy services.

xxiv. Nutrition Services.

b. Behavioral Health Services

Services for individuals age 20 and under, unless otherwise indicated:

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

- **a)** Partial hospitalization.
- **b)** Day treatment.
- **c)** Intensive outpatient.
- **d)** Medication management.
- **e)** Outpatient therapy (individual, family, or group).
- **f)** Injectable psychotropic medications.
- **g)** Substance use disorder treatment.
- **h)** Psychological evaluation and testing.
- **i)** Initial diagnostic interviews.
- **j)** Sex offender risk assessment.
- **k)** Community treatment aide (CTA) services.
- **l)** Hospital observation room services (up to 23 hours and 59 minutes in duration).
- **m)** Parent child interaction therapy.
- **n)** Child-parent psychotherapy.
- **o)** Applied behavioral analysis.
- **p)** Multi-systemic therapy.
- **q)** Functional family therapy.
- **r)** Peer support.

v. Rehabilitation services

- **a)** Day treatment/intensive outpatient.
- **b)** CTA services.
- **c)** Professional resource family care.
- **d)** Therapeutic group home.
- **e)** Community Support.
- **f)** Day rehabilitation.

28. Medical Transportation

a. The MCO must provide emergency and non-emergency medical transportation (NMET) for its members.

b. The MCO must establish policies for emergency transportation and NEMT services that ensures members' access to care and is compliant with Nebraska Medicaid guidelines for emergency transportation and NEMT.

c. The MCO must establish a broker to ensure NEMT access for its members. The broker must be responsible for and perform all administrative functions including, but not limited to:

i. Establishing a transportation network;

ii. Receiving NEMT services requests;

iii. Verifying member program eligibility and MCO enrollment;

iv. Screening members for mobility status and existing transportation resources;

v. Verifying coverage of program services, authorizing and arranging for transport; and

vi. Validating claims for provider payments

d. The direct provision of services shall be performed by transportation providers with active service provider agreements with the Department.

e. Customer Call Center

The MCO must ensure its broker maintains a toll-free telephone number, with access to oral interpretation services free of charge, and other toll-free voice and telecommunications devices for deaf clients. Toll-free telephone access for approving NEMT requests is required as follows:

i. Maintain sufficient personnel to perform the functions required herein for at least ten (10) consecutive hours during the hours of 8:00 a.m. through 7:00 p.m. Central Time, Monday through Friday;

ii. Maintain voice mail routing and response procedures;

iii. Provide twenty-four (24) hour toll-free access in order to provide information on how to access transportation for an urgent medical condition;

iv. Accept NEMT services requests by telephone and secure online ordering; and

v. Call performance standards per **Section IV.F.2.c** apply to the MCO's broker and must be included in the Member/Provider Call Center monthly report.

f. Service Approval

i. The MCO must ensure its broker is responsible for determining appropriateness for NEMT for members enrolled in the MCO per 471 NAC Chapter 27;

ii. The MCO must ensure its broker receives requests for NEMT, screen each request and, if approved, assign the trip to the most appropriate NEMT providers;

iii. The MCO must ensure that its broker requires no more than three (3) business days advance notice from the member, with the exception of urgent care or the availability of an Individual NEMT provider;

iv. The MCO must ensure that its broker establishes procedures regarding NEMT for standing orders so that members are not required to continually make arrangements for repetitive program appointments or services. Standing orders must include, but are not limited to outpatient therapy services, chemotherapy, dialysis, high-risk pregnancy prenatal care, and outpatient behavioral health services;

v. The MCO must ensure that its broker make a decision and arrange NEMT and provide notice to the member within one (1) business day of the request or as expeditiously as the member's health requires for urgent care;

vi. The MCO must ensure its broker arranges the most appropriate and lowest cost available mode of transportation based on each member's mobility status and personal capabilities;

vii. The MCO must ensure its broker maintain documentation supporting medical necessity for approval of a personal attendant/escort;

viii. The MCO must ensure its broker arrange NEMT for hospital discharges (acute, psychiatric, and state hospitals) when such requests are verified by hospital staff;

ix. The MCO must ensure its broker approve NEMT for one legally responsible adult to accompany children under the age of nineteen (19), if requested, or an adult selected by the legally responsible adult. The MCO's broker must ensure children age twelve (12) and under are not transported by a public or commercial NEMT provider without adult supervision; and

x. The MCO shall ensure consistent application of criteria for approval decisions and consultation with the member's medical service provider when appropriate.

g. NEMT Provider Service Delivery

The MCO must ensure that its broker ensures that NEMT network providers deliver service that allows members to arrive promptly for appointments, so that there is not an excessive wait for their

transportations. The pick-up and wait times should align with the following requirements:

i. The wait time for a pick-up to a scheduled appointment should not exceed sixty (60) minutes prior to the scheduled appointment time;

ii. The member should not wait more than thirty (30) minutes from drop off time to their scheduled appointment time;

iii. The wait time for a scheduled return trip, after an appointment, will not exceed sixty (60) minutes;

iv. Member's may be picked up on a "will call" basis, which will also not exceed sixty (60) minutes wait time after the NEMT provider is contacted for the return trip;

v. For multiple passenger trips, which are only allowed for commercial providers when the first member approves multi-loading, members should not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for transport, for an individual client using that mode, from the point of pick-up to the destination;

vi. Exceptions to service delivery times specified herein may be made for trips with pick-up or destinations outside the client's local area, or verified scheduled consecutive trips;

vii. Exceptions may also be made due to unusual situations such as exceptional distances in rural areas or other situations out of the control of the NEMT provider; and

viii. During periods of inclement weather conditions, the MCO's broker shall have written procedures in place that at a minimum includes notifying the members of the delay, the alternative schedule, and of any alternate pick-up arrangements.

h. The MCO must ensure its broker authorizes and reimburses a personal attendant/escort when medically necessary.

i. Record of Service Documentation

The MCO must ensure its broker require NEMT providers maintain a daily drivers' log. The daily drivers' log is excluded for fixed-route public transit systems, and commercial air. The NEMT providers'/escort's daily logs shall contain, at a minimum, the following information per transportation leg:

i. Driver/Escort's full name;

ii. Driver/Escort's signature or approved electronic signature;

iii. Vehicle Identification;

iv. Actual pick up time (clearly designate time using either a.m. or p.m. designation or military time) for each approved member;

v. Actual pick up address;

vi. Name of member transported, and, if applicable, the name of the accompanying adult or escort; and

vii. Member or parent/guardian signature or approved electronic signature and date.

j. The MCO must ensure its broker have an internal system of monitoring, analysis, evaluation, and improvement of the delivery of the NEMT service that:

i. Provides for regular utilization management and quality assessment reporting to the MCO and the Department, including profiling of NEMT provider utilization patterns;

ii. Provides for systematic data collection, analysis, and evaluation of performance; and

iii. Provides for timeliness for correction, and assignment of specific personnel to be responsible for ensuring compliance and follow up.

k. NEMT Information Technology Requirements

i. The MCO must ensure its broker has information technology systems that include unique or innovative features including a web-based system that allows remote notification of and access to errors or demonstration of benefits in a live system environment;

ii. The MCO must ensure its broker has information technology systems that accommodates screening, services approval, submission of claims for adjudication, payment, and any other information necessary to ensure that appropriate NEMT is approved and provided;

iii. The MCO must ensure its broker has information technology systems that includes a member and provider portal so that members may schedule trips and providers may accept/decline trips, schedule, and dispatch trips in the portal;

iv. The MCO must ensure its broker information system is designed to automate trip assignment to providers based first on lowest cost, appropriate mode of transportation and second on provider performance. The MCO's broker is prohibited from excluding trip assignments to NEMT providers that do not use tablet technology;

v. The MCO must ensure its broker information system is able to interface with tablet technology already in use by commercial carriers and/or NDOR supplied technology;

vi. The MCO must ensure its broker's information system has claims clearing practices with real-time access to client signature logs and GPS tagged trip verifications;

vii. The MCO must ensure its broker's information system allows for claims to be submitted electronically; and

viii. The MCO must ensure that its broker follow all other provisions of **Section IV. R** and **Section IV.S**.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 2/26/19

WellCare of Nebraska

By: _____

Printed Name: Lou Giangiulio

Title: Interim President - Nebraska

Date: 1/23/19

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

By: _____

Name: Matthew Van Patton

Title: Director

Date: 25 Feb 2019

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,066.55	$ 26.78	$ 1,093.34
AABD 21+ M&F	$ 1,531.11	$ 26.14	$ 1,557.25
AABD 21+ M&F-WWC	$ 3,332.07	$ 153.92	$ 3,485.99
CHIP M&F	$ 172.93	$ 2.04	$ 174.97
Family Under 1 M&F	$ 746.83	$ 12.03	$ 758.86
Family 01-05 M&F	$ 148.09	$ 2.45	$ 150.54
Family 06-20 F	$ 172.71	$ 2.41	$ 175.12
Family 06-20 M	$ 187.73	$ 2.09	$ 189.81
Family 21+ M&F	$ 451.23	$ 8.37	$ 459.60
Foster Care M&F	$ 510.44	$ 6.25	$ 516.69
Healthy Dual	$ 213.02	$ 2.60	$ 215.62
Dual LTC	$ 220.79	$ 0.53	$ 221.32
Non-Dual LTC	$ 3,330.52	$ 32.44	$ 3,362.96
Dual Waiver	$ 230.09	$ 1.25	$ 231.35
Non-Dual Waiver	$ 1,383.72	$ 16.11	$ 1,399.83
Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
599 CHIP - Cohort	$ 437.50	$ 6.60	$ 444.10
599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,935.35	$ 44.13	$ 4,979.48

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,392.02	$ 7.52	$ 1,399.54
AABD 21+ M&F	$ 1,680.53	$ 8.96	$ 1,689.49
AABD 21+ M&F-WWC	$ 3,539.94	$ 61.20	$ 3,601.15
CHIP M&F	$ 168.42	$ 0.92	$ 169.33
Family Under 1 M&F	$ 736.76	$ 7.69	$ 744.45
Family 01-05 M&F	$ 150.10	$ 0.74	$ 150.84
Family 06-20 F	$ 192.69	$ 0.75	$ 193.44
Family 06-20 M	$ 195.64	$ 0.55	$ 196.19
Family 21+ M&F	$ 538.57	$ 2.64	$ 541.21
Foster Care M&F	$ 547.71	$ 2.59	$ 550.31
Healthy Dual	$ 218.64	$ 0.33	$ 218.97
Dual LTC	$ 203.94	$ 0.09	$ 204.03
Non-Dual LTC	$ 2,057.60	$ 1.40	$ 2,059.00
Dual Waiver	$ 257.57	$ 0.12	$ 257.69
Non-Dual Waiver	$ 1,516.36	$ 5.10	$ 1,521.45
Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
599 CHIP - Cohort	$ 437.50	$ 6.60	$ 444.10
599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,996.83	$ 8.69	$ 5,005.53

Attachment 14
Quality Performance Program Measures – Contract Year Three

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	15%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children: The 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.	68%[1]	10%
Well-Child Visits in the First 15 Months of Life: The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	66%[2]	10%
Childhood Immunization Status: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 29%[3] Combination #10 - 19%[3]	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Meningococcal – 77%[1] Tdap –85 %[1] HPV – 21%[1]	Meningococcal –3% Tdap – 3% HPV—4%

Cancer Screening: ***Breast Cancer Screening –*** The percentage of woman 50-74 years of age who had a mammogram to screen for breast cancer. ***Cervical Cancer Screening –*** The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every 3 years, OR 2) Women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	BCS – 59%[1] CCS – 59%[1]	BCS—5% CCS--5%
Antidepressant Medication Management: The 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*** – The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ***Effective Continuation Phase Treatment*** – The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	EAPT –76%[3] ECPT – 66%[3]	5%
Follow Up Care for Children Prescribed Meds for ADHD-ADD: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who 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. Two rates are reported: ***Initiation Phase –*** The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *Continuation and* ***Maintenance (C&M) Phase*** – The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	IP – 46%[1] C&MP – 55%[1]	10%
Medication Management for People with Asthma: The percentage of Members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. For therapeutic purposes, the percentage of Members who remained on an asthma controller medication for at least 75% of their treatment period were monitored.	75% Med-adherent – 35%[1]	5%

***Note*: [1]** NCQA Hedis 2016 Medicaid HMO Mean Reference Group; https://www.ncqa.org/hedis/measures. **[2]** Medicaid Health Care Quality Measures Adult/Child Chart Pack Top Quartile Reference Group

https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-chart-pack.pdf. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html. (Well-Child Visits in the First 15 Months of Life: All MCOs met or exceeded mean NCQA Reference Group)

[3] MCO Aggregate Highest Performer + 5% (All MCOs met or exceeded both NCQA and Core Adult Set Reference Group Baseline)

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	11/06/18
BUSINESS UNIT	BUYER
25710178	VACANT (AS)

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

CONTRACT NUMBER
71164 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2021

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

AMENDMENT FIVE (5) AS ATTACHED. (11/06/18 bb)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE	409,151,871.0000	$	1.0000	409,151,871.00

DHHS DIVISION DIRECTOR

11/9/18 11/6/18
BUYER

11/9/18
MATERIEL ADMINISTRATOR

R43500;MISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	11/06/18
BUSINESS UNIT	BUYER
25710178	VACANT (AS)
VENDOR NUMBER: 1247761	

CONTRACT NUMBER
71164 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
	INITIAL CONTRACT TERM YEAR 2				
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

BUYER INITIALS

AMENDMENT FIVE
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the "amendment") to Contract 71164 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

Amend the Contract End date from December 31, 2022 to December 31, 2021, with an option to be renewed for two (2) additional one (1) year periods as mutually agreed upon by both parties.

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: David Zwart

Title: Materiel Administrator

Date: 11/7/18

WellCare of Nebraska

By: _____

Printed Name: Lauralie Rubel

Title: State President

Date: 11/1/18

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

By: _____

Name: Matthew VanPatton

Title: Director

Date: 11/8/18

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,066.55	$ 26.78	$ 1,093.34
AABD 21+ M&F	$ 1,531.11	$ 26.14	$ 1,557.25
AABD 21+ M&F-WWC	$ 3,332.07	$ 153.92	$ 3,485.99
CHIP M&F	$ 172.93	$ 2.04	$ 174.97
Family Under 1 M&F	$ 746.83	$ 12.03	$ 758.86
Family 01-05 M&F	$ 148.09	$ 2.45	$ 150.54
Family 06-20 F	$ 172.71	$ 2.41	$ 175.12
Family 06-20 M	$ 187.73	$ 2.09	$ 189.81
Family 21+ M&F	$ 451.23	$ 8.37	$ 459.60
Foster Care M&F	$ 510.44	$ 6.25	$ 516.69
Healthy Dual	$ 213.02	$ 2.60	$ 215.62
Dual LTC	$ 220.79	$ 0.53	$ 221.32
Non-Dual LTC	$ 3,330.52	$ 32.44	$ 3,362.96
Dual Waiver	$ 230.09	$ 1.25	$ 231.35
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Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
599 CHIP - Cohort	$ 437.50	$ 6.60	$ 444.10
599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,935.35	$ 44.13	$ 4,979.48

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$ 1,392.02	$ 7.52	$ 1,399.54
AABD 21+ M&F	$ 1,680.53	$ 8.96	$ 1,689.49
AABD 21+ M&F-WWC	$ 3,539.94	$ 61.20	$ 3,601.15
CHIP M&F	$ 168.42	$ 0.92	$ 169.33
Family Under 1 M&F	$ 736.76	$ 7.69	$ 744.45
Family 01-05 M&F	$ 150.10	$ 0.74	$ 150.84
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Family 06-20 M	$ 195.64	$ 0.55	$ 196.19
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Foster Care M&F	$ 547.71	$ 2.59	$ 550.31
Healthy Dual	$ 218.64	$ 0.33	$ 218.97
Dual LTC	$ 203.94	$ 0.09	$ 204.03
Non-Dual LTC	$ 2,057.60	$ 1.40	$ 2,059.00
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Katie Beckett 00-18 M&F	$ 11,328.47	$ 35.95	$ 11,364.41
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599 CHIP - Supplemental	$ 4,667.30	$ 50.30	$ 4,717.60
Maternity	$ 4,996.83	$ 8.69	$ 5,005.53

Attachment 14
Quality Performance Program Measures – Contract Year Three

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	15%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	5%
Lead Screening in Children: The 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.	68%[1]	10%
Well-Child Visits in the First 15 Months of Life: The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	66%[2]	10%
Childhood Immunization Status: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 29%[3] Combination #10 - 19%[3]	Combination #2 - 5% Combination #10 - 5%
Immunization for Adolescents: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	Meningococcal – 77%[1] Tdap –85 %[1] HPV – 21%[1]	Meningococcal –3% Tdap – 3% HPV—4%

Cancer Screening: ***Breast Cancer Screening –*** The percentage of woman 50-74 years of age who had a mammogram to screen for breast cancer. ***Cervical Cancer Screening –*** The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: 1) Women age 21-64 who had cervical cytology performed every 3 years, OR 2) Women age 30-64 who had cervical cytology/human papillomavirus co-testing performed every 5 years.	BCS – 59%[1] CCS – 59%[1]	BCS—5% CCS--5%
Antidepressant Medication Management: The 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*** – The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ***Effective Continuation Phase Treatment*** – The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	EAPT –76%[3] ECPT – 66%[3]	5%
Follow Up Care for Children Prescribed Meds for ADHD-ADD: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who 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. Two rates are reported: ***Initiation Phase –*** The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. *Continuation and* ***Maintenance (C&M) Phase*** – The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	IP – 46%[1] C&MP – 55%[1]	10%
Medication Management for People with Asthma: The percentage of Members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. For therapeutic purposes, the percentage of Members who remained on an asthma controller medication for at least 75% of their treatment period were monitored.	75% Med-adherent – 35%[1]	5%

***Note*: [1]** NCQA Hedis 2016 Medicaid HMO Mean Reference Group; https://www.ncqa.org/hedis/measures. **[2]** Medicaid Health Care Quality Measures Adult/Child Chart Pack Top Quartile Reference Group

https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-chart-pack.pdf. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html. (Well-Child Visits in the First 15 Months of Life: All MCOs met or exceeded mean NCQA Reference Group)

[3] MCO Aggregate Highest Performer + 5% (All MCOs met or exceeded both NCQA and Core Adult Set Reference Group Baseline)

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	05/17/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

CONTRACT NUMBER
71164 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

AMENDMENT FOUR (4) AS ATTACHED. (5/17/18 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00

DHHS Division Director

5/24/18
BUYER
8/29/18
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	05/17/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

VENDOR NUMBER: 1247761

CONTRACT NUMBER
71164 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

JE
BUYER INITIALS

AMENDMENT FOUR
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the "amendment") to Contract 71164 04 (the "contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **MODIFICATIONS:** The Parties hereto modify the following sections:

Section IV.E – COVERED SERVICES AND BENEFITS

25. Durable Medical Equipment

c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to:
i) Nursing facility, or
ii) Intermediate care facility for individuals with developmental disabilities

Section IV.P - MCO REIMBURSEMENT

10. MLTC Quality Performance Program

e. Each year of the contract constitutes a performance year, beginning on the contract start date. MLTC will assess the MCO's performance based on the measures annually and notify the MCO of the amount of the earned hold-back and unearned (forfeited) hold-back. MLTC will make this determination within eleven (11) months after the end of each contract year.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

Section IV.Z – FFS CLAIMS MANAGEMENT AND PROCESSING

III. **Attachment 11 – RATES has been updated.**
Rates for July 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: David D Zwart

Title: Materiel Administrator

Date: 8/24/18

WellCare

By: _____

Printed Name: Lauralie Rubel

Title: Plan President

Date: 8/20/18

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

By: _____

Name: Matthew VanPatton

Title: Director

Date: 27 Aug 18

Attachment 11 – Rates

Rating Region 1			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,045.32	$14.69	$1,060.02
AABD 21+ M&F	$1,496.65	$16.49	$1,513.14
AABD 21+ M&F-WWC	$3,482.24	$49.60	$3,531.84
CHIP M&F	$177.18	$1.06	$178.24
Family Under 1 M&F	$760.77	$14.40	$775.17
Family 01-05 M&F	$161.98	$1.24	$163.22
Family 06-20 F	$165.63	$1.02	$166.65
Family 06-20 M	$181.86	$0.83	$182.68
Family 21+ M&F	$424.08	$3.44	$427.51
Foster Care M&F	$532.88	$3.83	$536.71
Healthy Dual	$277.64	$4.04	$281.68
Dual LTC	$233.62	$2.86	$236.48
Non-Dual LTC	$3,603.78	$52.66	$3,656.43
Dual Waiver	$285.38	$3.71	$289.10
Non-Dual Waiver	$1,756.88	$28.48	$1,785.36
Katie Beckett 00-18 M&F	$13,978.01	$13.55	$13,991.56
599 CHIP - Cohort	$419.38	$10.35	$429.73
599 CHIP - Supplemental	$4,714.41	$74.83	$4,789.24
Maternity	$8,111.44	$134.69	$8,246.12

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Pass-through**	**Payment Rate**
AABD 00-20 M&F	$1,239.57	$10.17	$1,249.74
AABD 21+ M&F	$1,717.97	$6.63	$1,724.60
AABD 21+ M&F-WWC	$4,519.68	$3.61	$4,523.29
CHIP M&F	$178.44	$0.76	$179.20
Family Under 1 M&F	$692.77	$12.22	$705.00
Family 01-05 M&F	$160.12	$0.54	$160.67
Family 06-20 F	$177.29	$0.61	$177.90
Family 06-20 M	$204.81	$0.50	$205.31
Family 21+ M&F	$491.09	$1.28	$492.37
Foster Care M&F	$537.67	$1.59	$539.26
Healthy Dual	$231.03	$1.75	$232.78
Dual LTC	$196.11	$1.04	$197.15
Non-Dual LTC	$2,271.29	$11.94	$2,283.23
Dual Waiver	$254.34	$1.85	$256.20
Non-Dual Waiver	$1,627.45	$12.76	$1,640.21
Katie Beckett 00-18 M&F	$13,978.01	$13.55	$13,991.56
599 CHIP - Cohort	$419.38	$10.35	$429.73
599 CHIP - Supplemental	$4,714.41	$74.83	$4,789.24
Maternity	$8,119.13	$19.62	$8,138.76

WellCare Health Plans
Lauralie Rubel
State President

August 20, 2018

Jennifer Eloge, Buyer III
Nebraska Department of Administrative Services
1526 K Street, Suite 130
Lincoln, NE 68508

RE: Amendment Four

Dear Jen:

Enclosed please find a signed original of Amendment Four to MLTC's MCO Agreement with WellCare of Nebraska, Inc.

Thank you for your patience as WellCare worked through our questions with representatives from MLTC. As always, we appreciate the privilege of serving Nebraskans with Heritage Health.

Sincerely,

Lauralie Rubel
President/CEO

cc: Lori Hack, Regulatory Affairs

Office Address: 8055 O Street, Suite 300, Lincoln, NE – 68510
Telephone: 402-328-5402 / Email: Lauralie.Rubel@wellcare.com

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	11/06/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

CONTRACT NUMBER
71164 O4

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

AMENDMENT THREE (3) AS ATTACHED. (11/6/17 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00

DHHS Division Director

Michelle Thompson 11.15.17
BUYER

21NOV17
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	11/06/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 1247761

CONTRACT NUMBER
71164 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	Total Order				**1,228,166,329.00**

MT 11.15.17
BUYER INITIALS

AMENDMENT THREE
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska. make this Amendment (the Amendment") to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **MODIFICATIONS:** The Parties hereto modify the following sections effective January 1, 2018:

A. Section IV.Q. – Provider Reimbursement

16. Pharmacy Reimbursement

d. The MCO's dispensing fee reimbursement must be, at a minimum, the Medicaid FFS rate at the time of contract start for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider.

B. Attachment 11 – Rates

January 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

C. Attachment 14 – Quality Performance Program Measures-Contract Year Two

The Quality Performance Program measures have been revised for the time period January 1, 2018, through December 31, 2018, and are set forth in the Amended Attachment 14 attached hereto and made a part hereof.

D. Attachment 38 – Revised Reporting Requirements

The reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska
By: Doug Wilken

Printed Name: Doug Wilken

Title: Materiel Administrator

Date: 21 NOV 17

WellCare of Nebraska
By: Lauralie M. Rubel

Printed Name: Lauralie M. Rubel

Title: President / CEO

Date: 11/1/17

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

By: [signature]

Name: Thomas "Rocky" Thompson

Title: Interim Director

Date: 11/13/2017

Wellcare – HH Risk Adjusted Rates – 1.1.2018

Attachment 11 – Rates

Rating Region 1			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Pass-through	Payment Rate
AABD 00-20 M&F	$ 1,077.27	$ 20.77	$ 1,098.04
AABD 21+ M&F	$ 1,551.28	$ 23.32	$ 1,574.60
AABD 21+ M&F-WWC	$ 3,311.18	$ 70.12	$ 3,381.30
CHIP M&F	$ 174.77	$ 1.50	$ 176.27
Family Under 1 M&F	$ 718.19	$ 20.36	$ 738.55
Family 01-05 M&F	$ 157.20	$ 1.75	$ 158.95
Family 06-20 F	$ 165.83	$ 1.44	$ 167.27
Family 06-20 M	$ 182.99	$ 1.17	$ 184.16
Family 21+ M&F	$ 410.36	$ 4.86	$ 415.22
Foster Care M&F	$ 507.07	$ 5.41	$ 512.48
Healthy Dual	$ 264.32	$ 5.71	$ 270.03
Dual LTC	$ 222.35	$ 4.04	$ 226.39
Non-Dual LTC	$ 3,436.52	$ 74.44	$ 3,510.96
Dual Waiver	$ 271.66	$ 5.25	$ 276.91
Non-Dual Waiver	$ 1,673.38	$ 40.26	$ 1,713.64
Katie Beckett 00-18 M&F	$ 13,305.61	$ 19.15	$ 13,324.76
599 CHIP - Cohort	$ 399.04	$ 14.63	$ 413.67
599 CHIP - Supplemental	$ 4,586.72	$ 105.79	$ 4,692.51
Maternity	$ 8,002.22	$ 190.41	$ 8,192.63

Rating Region 2			
Category of Aid	Non-UNMC Portion of the Rate	UNMC Pass-through	Payment Rate
AABD 00-20 M&F	$ 1,211.86	$ 14.37	$ 1,226.23
AABD 21+ M&F	$ 1,722.73	$ 9.37	$ 1,732.10
AABD 21+ M&F-WWC	$ 4,304.25	$ 5.11	$ 4,309.36
CHIP M&F	$ 173.40	$ 1.08	$ 174.48
Family Under 1 M&F	$ 654.31	$ 17.28	$ 671.59
Family 01-05 M&F	$ 152.05	$ 0.77	$ 152.82
Family 06-20 F	$ 174.66	$ 0.86	$ 175.52
Family 06-20 M	$ 204.16	$ 0.71	$ 204.87
Family 21+ M&F	$ 475.30	$ 1.81	$ 477.11
Foster Care M&F	$ 512.34	$ 2.25	$ 514.59
Healthy Dual	$ 219.99	$ 2.48	$ 222.47
Dual LTC	$ 186.61	$ 1.47	$ 188.08
Non-Dual LTC	$ 2,172.50	$ 16.87	$ 2,189.37
Dual Waiver	$ 242.14	$ 2.62	$ 244.76
Non-Dual Waiver	$ 1,549.27	$ 18.04	$ 1,567.31
Katie Beckett 00-18 M&F	$ 13,305.61	$ 19.15	$ 13,324.76
599 CHIP - Cohort	$ 399.04	$ 14.63	$ 413.67
599 CHIP - Supplemental	$ 4,586.72	$ 105.79	$ 4,692.51
Maternity	$ 8,033.16	$ 27.74	$ 8,060.90

Attachment 14
Quality Performance Program Measures – Contract Year Two

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 10 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<2%	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 20 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%
Lead Screening in Children - The 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.	65%	10%
Well-Child Visits in the First 15 Months of Life - The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: 0 Visits, 1 Visit, 2 Visits, 3 Visits, 4 Visits, 5 Visits, 6 Visits or more	52% with 6 Visits or more	10%
Childhood Immunization Status - The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Combination #2 - 19% Combination #10 - 8%	Combination #2 - 5% Combination #10 - 5%

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

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

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Behavioral Health Children in Residential Treatment	Summary data, by member, on children in residential treatment including information on: wait list, discharges, children currently in treatment, and restraints and seclusions.	Monthly
Behavioral Health Critical Incident	Summary data on the number of critical incident reports by behavioral health facility and location.	Monthly
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly

Enrollment Reconciliation Report	Report identifying any member for whom the MCO received a capitation payment for a month in which the member was never enrolled per official enrollment files	Monthly
Hospice Monthly Report	Data summarizing hospice authorizations, admissions, and discharges.	Monthly
Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
PDL Load Report	Data documenting that the MCO received and loaded the PDL file per contract requirements.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Restricted Services Report	Summary data related to members on restricted services.	Monthly
Third Party Resource	Summary data of all instances in which an MCO identified a TPR.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
Eligible and Number of BH Services Recipients	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	Quarterly
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements and Attachment 39 – Revised Access Standards.	Quarterly
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC December 15, March 15, June 15 and September 15 for the previous calendar quarter.

Attachment 38 – Revised Reporting Requirements

MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Admit and Re-Admit to Psych Inpatient	Data of inpatient or residential admissions and re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly
MLTC Reporting Database: Out of Network Referrals	Data regarding out of network provider authorization requests.	Quarterly
NF Skilled Stay Authorizations	Report on the number of skilled NF stay authorizations and denials, as well as PASRR compliance verification	Quarterly
PDL Compliance Report	Data documenting accuracy in dispensing medications in PDL categories.	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly
Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 39 – Revised Access Standards.	Quarterly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly

Quality Oversight Committee Report	Committee activity summary as described in Section IV.M - Quality Management.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly IHS Tracking	Data and metrics summarizing Indian Health Service delivery.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Subrogation	Data summarizing new and ongoing instances of subrogation.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
MRO Reporting	Data related to Medicaid mental health authorization requests for all members ages 19+ for Medicaid Rehab Option Services	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by June 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually by June 30
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually

Attachment 38 – Revised Reporting Requirements

HEDIS Report	HEDIS results.	Annually by June 30
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from September 1 to August 31 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than September 10
Medication Therapy Management Report	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	Annually
MLTC Reporting Database: CAHPS – Adult	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data regarding the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data regarding the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually by November 1
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Utilization Management	Data and analysis summarizing the MCO's annual evaluation of its UM program.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; Upon request of MLTC, no later than June 1
IRS Form 8963	Copy of form	Annually; By Sept. 5

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	06/23/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
71164 O4

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

AMENDMENT TWO (2) AS ATTACHED. (6/23/17 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

7/3/17 Michelle Thompson 7.3.17
BUYER

7-5-17
Douglas Walker 6 July 17
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
2 of 2	06/23/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)
VENDOR NUMBER: 1247761	

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
71164 O4

MT 7.3.17
BUYER INITIALS

AMENDMENT TWO
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between the State of Nebraska and WellCare of Nebraska

The State of Nebraska and WellCare of Nebraska make this Amendment (the Amendment") to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. MODIFICATIONS: The Parties hereto modify the following sections upon execution of this Amendment:

A. Glossary of Terms

Adverse Benefit Determination (formerly referred to as "Action"):
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of the MCO to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments and other enrollee financial liabilities.

B. Section IV.B.7.c.iv

If the member's request for disenrollment is denied, the member can file a grievance to the enrollment broker or appeal the decision through the State's fair hearing process.

C. Section IV.E. – Covered Services and Benefits

8. Core Benefits and Services

<u>The following services represent a minimum benefit package that the MCO must provide to its members:</u>

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.
iii. Ambulatory surgical center (ASC) services.
iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.
v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).
vi. Services provided in Indian Health Service (IHS) facilities.
vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.
viii. Radiology services.
ix. Health Check (EPSDT) services.
x. Home health services.
xi. Private duty nursing services.
xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).
xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.
xiv. Podiatry services.
xv. Chiropractic services.
xvi. Vision services.
xvii. Free standing birth center services.
xviii. Hospice services, except when provided in a nursing facility.
xix. Skilled/rehabilitative and transitional nursing facility services.
xx. Ambulance services.
xxi. Non-emergency ambulance transportation.
xxii. Transplant services.
xxiii. Pharmacy services.
xxiv. Nutrition Services

b. Behavioral Health Services

<u>Services for individuals age 20 and under, unless otherwise indicated:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Day treatment.
c) Intensive outpatient.
d) Medication management.
e) Outpatient therapy (individual, family, or group).
f) Injectable psychotropic medications.
g) Substance use disorder treatment.
h) Psychological evaluation and testing.
i) Initial diagnostic interviews.
j) Sex offender risk assessment.
k) Community treatment aide (CTA) services.
l) Comprehensive child and adolescent assessment (CCAA).
m) CCAA addendum.
n) Hospital observation room services (up to 23 hours and 59 minutes in duration).
o) Parent child interaction therapy.
p) Child-parent psychotherapy.
q) Applied behavioral analysis.
r) Multi-systemic therapy.
s) Functional family therapy.
t) Peer support.

v. Rehabilitation services

a) Day treatment/intensive outpatient.
b) CTA services.
c) Professional resource family care.
d) Therapeutic group home.

<u>Services for adults age 21 and over:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital services (acute and sub-acute).

iii. Outpatient assessment and treatment:

a) Partial hospitalization.
b) Social detoxification.
c) Day treatment.
d) Intensive outpatient.
e) Medication management.

f) Outpatient therapy (individual, family, or group).
g) Injectable psychotropic medications.
h) Substance use disorder treatment.
i) Psychological evaluation and testing.
j) Electroconvulsive therapy.
k) Initial diagnostic interviews.
~~l) Ambulatory detoxification.~~
l) In-home psychiatric nursing.
m) Peer Support

iv. Rehabilitation services

a) Dual-disorder residential.
b) Intermediate residential (SUD).
c) Short-term residential.
d) Halfway house.
e) Therapeutic community (SUD only).
f) Community support.
g) Psychiatric residential rehabilitation.
h) Secure residential rehabilitation.
i) Assertive community treatment (ACT) and Alternative (Alt) ACT.
j) Community support.
k) Day rehabilitation.

11. Pharmacy Services

c. Nebraska Medicaid Preferred Drug List

i. The MCO must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
ii. The MLTC PDL vendor will provide to the MCO a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC.
iii. The MCO must begin updating the pharmacy claim system within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
iv. The MCO must, at the direction of MLTC, begin to perform off-cycle PDL file updates within twenty-four (24) hours of file receipt of the PDL file and loading must be complete within five (5) business days.
v. The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes.

vi. The MCO is not authorized to and must not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. MLTC or its designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebateable exclusively to Nebraska Medicaid.

vii. The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. Written final approval of nominees is made by MLTC.

D. Section IV.H. – Grievances and Appeals

4. Appeal Process

b. Following receipt of a notification of an adverse benefit determination by the MCO, the member has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.

e. The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

I. Make reasonable efforts to give the member prompt verbal notice of the delay.

II. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.

III. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

6. Continuation of Benefits

a. The MCO must continue a member's benefits if all of the following occur:

i. The member files the request for an appeal timely;

ii. The appeal involves the termination, suspension, or reduction of previously authorized services;

iii. The services were ordered by an authorized provider;

iv. The period covered by the original authorization has not expired; and

v. The member timely files for continuation of benefits, timely files means on or before the later of the following:

i. Within ten (10) calendar days of the MCO sending the notice of adverse benefit determination.

ii. The intended effective date of the MCO's proposed adverse benefit determination.

b. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

vi. The member withdraws the appeal or request for state fair hearing.
vii. The member fails to request a state fair and continuation of benefits within 10 calendar days after the MCO send the notice of an adverse resolution to the member's appeal.
viii. The state fair hearing office issues a hearing decision adverse to the member.
ix. The authorization expires or authorization service limits are met.

c. The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action to the extent that the services were furnished solely because of the requirements of this section.

7. Access to State Fair Hearings

c. The member or the member's representative (if any) may request a state fair hearing no later than 120 calendar days from the date of the MCO's notice of resolution.

E. Section IV.P. – MCO Reimbursement

5. Supplemental Delivery Payments

l. The MCO must not bill for a supplemental maternity payment until the delivery is paid by the MCO. The MCO must submit encounter data evidence of the delivery to be eligible to receive a supplemental delivery payment.

16. Medicare Crossover Methodology

a. The MCO must use the methodology for reconciling Medicare crossover claim experience for the period of July 1, 2017, through December 31, 2017, as set forth in Attachment 41 – Medicare Crossover Methodology.

F. Section IV.Q. – Provider Reimbursement

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the MCO must:
   i. Provide I/T/U providers, whether participating in the network or not, payment for covered services provided to Indian

members who are eligible to receive services from these providers either:

i. At the all-inclusive encounter rate that the Unites States Department of Health and Human Services establishes.

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

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

G. Section IV.S. – Claims Management

4. Drug Claims Processing

j. The MCO will send its pharmacy encounter claims to Magellan via the FTP process. The MCO will send the encounter claims in the current State of Nebraska proprietary format and must send files from the preceding month no later than the eighth (8th) day of the following month.

H. Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative

The MCO must utilize prior authorization and additional edits for psychotropic drugs prescribed to youth, at a minimum, following the current DHHS guidelines.

I. Attachment 14 – Quality Performance Program Measures – Contract Year One

The updated Attachment 14 is attached hereto and made a part hereof.

J. Attachment 38 – Revised Reporting Requirements

The reporting requirements and templates have been changed. The updated requirements and report titles are set forth in the amended Attachment 38 attached hereto and made a part hereof.

K. Attachment 11 – Rates

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2017, through December 31, 2017, and are set forth in the amended Attachment 11 attached hereto and made a part hereof.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: Douglas Leiellen

Name: ~~Bo Botelho~~ Doug Wilken

Title: Materiel Administrator

Date: 6 July 17

WellCare of Nebraska

By: Lauralie M. Rubel

Name: Lauralie M. Rubel

Title: Plan President

Date: 6/16/17

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

By:

Name: Thomas N Thompson

Title: Interim Director

Date: 6/29/2017

ATTACHMENT 11 - RATES Effective July 1, 2017			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,216.27	$ 21.85	$ 1,238.12
AABD 21+M&F	$ 1,763.79	$ 24.33	$ 1,788.12
AABD 21+M&F-WWC	$ 3,076.40	$ 70.82	$ 3,147.22
CHIP M&F	$ 179.27	$ 1.33	$ 180.60
Family Under 1 M&F	$ 710.56	$ 20.25	$ 730.81
Family 01-05 M&F	$ 158.35	$ 1.73	$ 160.08
Family 06-20 F	$ 174.79	$ 1.40	$ 176.19
Family 06-20 M	$ 191.75	$ 1.10	$ 192.85
Family 21+ M&F	$ 417.76	$ 4.96	$ 422.72
Foster Care M&F	$ 513.33	$ 5.55	$ 518.88
Healthy Dual	$ 257.06	$ 6.40	$ 263.46
Dual LTC	$ 221.47	$ 4.43	$ 225.90
Non-Dual LTC	$ 3,419.62	$ 72.91	$ 3,492.53
Dual Waiver	$ 265.57	$ 5.65	$ 271.22
Non-Dual Waiver	$ 1,689.23	$ 41.37	$ 1,730.60
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,093.98	$ 212.79	$ 8,306.77

Rating Region 2			
CATEGORY OF AID	NON-UNMC PORTION OF THE RATE	UNMC PASS-THROUGH	PAYMENT RATE
AABD 00-20 M&F	$ 1,198.92	$ 13.91	$ 1,212.83
AABD 21+ M&F	$ 1,827.85	$ 8.79	$ 1,836.64
AABD 21+ M&F-WWC	$ 3,884.51	$ 4.26	$ 3,888.77
CHIP M&F	$ 177.43	$ 0.88	$ 178.31
Family Under 1 M&F	$ 651.15	$ 18.64	$ 669.79
Family 01-05 M&F	$ 155.09	$ 0.68	$ 155.77
Familly 06-20 F	$ 179.88	$ 0.60	$ 180.48
Family 06-20 M	$ 212.55	$ 0.80	$ 213.35
Family 21+ M&F	$ 487.61	$ 1.49	$ 489.10
Foster Care M&F	$ 515.25	$ 3.46	$ 518.71
Healthy Dual	$ 213.38	$ 2.35	$ 215.73
Dual LTC	$ 186.89	$ 1.37	$ 188.26
Non-Dual LTC	$ 2,212.90	$ 24.75	$ 2,237.65
Dual Waiver	$ 231.96	$ 2.77	$ 234.73
Non-Dual Waiver	$ 1,574.71	$ 22.56	$ 1,597.27
Katie Beckett 00-18 M&F	$ 13,552.65	$ 35.65	$ 13,588.30
599 CHIP - Cohort	$ 385.19	$ 16.05	$ 401.24
599 CHIP - Supplemental	$ 5,012.09	$ 134.95	$ 5,147.04
Maternity	$ 8,139.57	$ 35.34	$ 8,174.91

Attachment 14
Quality Performance Program Measures – Contract Year One

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the clean claim.	95% within 15 business days	20%
Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven calendar days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 calendar days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 30 days	10%
Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.	95% within 60 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%

Attachment 38 – Revised Reporting Requirements

Bi-Weekly	Due the 1st and 15th of the month.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

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

Ad Hoc Deliverables	**Description**	**Due Date**
Criminal Report	Pursuant to IV.T.6, the MCO will report any criminal findings of a provider. The findings should include the provider identifying information (name/NPI/Taxonomy/complete address) and nature of criminal offence.	Ad Hoc
Standard Financial Reports	MLTC will request this with adequate notice given to the MCO.	Ad Hoc
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to IV.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15).	Bi-Weekly
Monthly Deliverables	**Description**	**Due Date**
Behavioral Health Wait and Wards in Residential Treatment	Summary data, by member, of the number of days before a member is accepted into a program and, by member, the number of days before the member is admitted to the program.	Monthly
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.S - Claims Management.	Monthly
Eligible and Number of BH Services Recipients	Summary data documenting by cohort the number of members eligible for and receiving behavioral health services.	Monthly
Hospice Monthly Report	Data summarizing hospice authorizations, admissions, and discharges.	Monthly

Member-Provider Call Center	Pursuant to Section IV.F, data summarizing relevant call center operations.	Monthly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	15th day of the following calendar month for each of the first 6 months, then Quarterly
MLTC Reporting Database: Out of State Placement Table	Summary data on admissions and discharges of members placed in out of state residential treatment.	Monthly
Monthly Claims Report	Summary data on claims system.	Monthly
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Monthly
Monthly FWA Report	Summary of investigations as described in Section IV.O – Program Integrity.	Monthly
PDL Load Report	Data documenting that the MCO received and loaded the PDL file per contract requirements.	Monthly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Monthly
Pharmacy Claims Report	Summary data on pharmacy claims system.	Monthly
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly
Provider Call Center Quality	MCO's report of its measurement and monitoring of the accuracy of responses by the provider call center staff.	Monthly
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly
Psychotropic Medications for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Monthly
Restricted Services Report	Summary data related to members on restricted services.	Monthly
Third Party Resource	Summary data of all instances in which an MCO identified a TPR.	Monthly
Quarterly Deliverables	**Description**	**Due Date**
BH Residential Beds and Critical Incident	Summary data on the number of behavioral health-related residential beds available statewide and the number of critical incident reports by behavioral health facility and location.	Quarterly
GEO Access	Details of the MCO's network, including GeoAccess reports, as described in Section IV.I – Provider Network Requirements.	Quarterly
IHS Pharmacy Report	Summary data related to IHS pharmacy services.	Quarterly

LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19	Quarterly: reports submitted to the Nebraska Legislature are due Jan. 1, Apr. 1, July 1, and Oct. 1. The MCO must submit these reports to MLTC December 15, March 15, June 15 and September 15 for the previous calendar quarter.
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue.	Quarterly and Annually; Due 45 calendar days after the end of the reported period.
MLTC Reporting Database: 30 Day Behavioral Health ER Visits	Summary data of ER visits with a behavioral health diagnosis subsequent to an inpatient behavioral health discharge.	Quarterly
MLTC Reporting Database: 30 Day Inpatient Re-Admits	Summary data of inpatient re-admissions.	Quarterly
MLTC Reporting Database: Admit and Re-Admit to Psych Inpatient	Summary data of inpatient or residential admissions and re-admissions.	Quarterly
MLTC Reporting Database: Care Management Log	Summary data of member assessment and their care management.	Quarterly
MLTC Reporting Database: Grievance System Log table	Pursuant to Section IV.H, data regarding the grievance and appeal systems.	Quarterly, after the first 6 months of the contract. Monthly for the first 6 months of the contract.
MLTC Reporting Database: Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	Quarterly
MLTC Reporting Database: Restraint and Seclusion	Data summarized, by behavioral health provider, on the number of incidents of restraint or seclusion by program type and location.	Quarterly
Network Adequacy and Cultural Competency Report	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 2 - Access Standards; including data and metrics on cultural competency access as determined by MLTC.	Quarterly
PDL Compliance Report	Data documenting accuracy in dispensing medications in PDL categories.	Quarterly
Pharmacy Prospective DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Pharmacy Retro-DUR Education Intervention Report	Project update in a format approved by MLTC.	Quarterly

Pharmacy Utilization Management Report	Data summarizing pharmacy utilization management categories including, but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, top 100 drugs, and top 50 drug categories listed by expenditures and claim count.	Quarterly
Provider Network and PCP Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 2 - Access Standards.	Quarterly
Quality Oversight Committee Report	Committee activity summary as described in Section IV.M - Quality Management.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Quarterly IHS Tracking	Data and metrics summarizing Indian Health Service delivery.	Quarterly
Quarterly Value-Added	Summary of value added services as agreed upon by the MCO and MLTC.	Quarterly; Due 45 days after the most recent calendar quarter
Service Verification	Service verification summary as described in Section IV.O – Program Integrity, Section IV.S – Claims Management, and Section IV. T – Reporting and Deliverables.	Quarterly
Subrogation	Data summarizing new and ongoing instances of subrogation.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Claims Auditing Reporting Requirements	A report on error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.	June 30 and December 31
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section IV.M - Quality Management.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	Annually
CAP	Results and status of all corrective action plans by provider type.	Annually
Child Core Measures	CHIPRA performance measure results.	Annually

Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Annually; No later than March 31, State initiates the request
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Annually
HEDIS Report	HEDIS results.	Annually
Medication Therapy Management Report	Data and analysis that summarizes MTM program activities, the effectiveness of the program over the reporting period, and the objectives and implementation plan for the next reporting period.	Annually
MLTC Reporting Database: CAHPS -- Adult	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP with CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: CAHPS – Child/CHIP without CCC	Data and analysis summarizing results of the annual member satisfaction survey.	Annually
MLTC Reporting Database: Provider and Facility Survey	Data and analysis summarizing results of the annual provider and facility satisfaction surveys. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 days prior to its administration.	Annually
Network Development Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	Annually
PIP Report	Annual report of all PIPs.	Annually
Quality Management Work Plan and Program Evaluation	Discussion of the MCO's quality goals, initiatives and work plan; as well as data and analysis summarizing the results of the annual quality work plan. All as described in Section IV.M – Quality Management.	Annually
Utilization Management	Data and analysis summarizing the MCO's annual evaluation of its UM program.	Annually
Department of Insurance Financial Report	Copy of annual audited financial statement	**Annually; Upon request of MLTC, no later than June 1**
IRS Form 8963	Copy of form	**Annually; By Sept. 5**

Attachment 41 --
Medicare Crossover Methodology

The State of Nebraska is implementing a change in its methodology for reimbursing providers for crossover claims, effective July 1, 2017. The new approach will consist of Medicaid being responsible for the lesser of the Medicaid allowed amount, and the Medicare cost-sharing remaining to be paid for each claim. For example, if the Medicare allowed amount for a claim is $100, the Medicaid allowed amount is $75, and Medicare has already paid $80 (assuming 20% coinsurance), then Medicaid would pay $0. If the Medicaid allowed amount were instead $85, then Medicaid would pay $5 ($85 Medicaid allowed - $80 Medicare paid).

Due to the significant impact this adjustment has on the dually eligible populations, the State and MCOs have agreed to the conduct a risk corridor surrounding crossover claim payments for the July – December 2017 period, which provides protection against misestimating, but still provides limited risk transfer between the parties.

The process for the risk corridor reconciliation will consist of a comparison of the actual PMPM experienced for crossover claims during the July – December 2017 contract period, and the assumed crossover PMPM within the capitation rates. The initial calculation will be done by MCO, Rating Region (1 and 2), and Dual COA (Healthy Dual, Dual LTC, and Dual Waiver). However, after calculating the comparison at the detailed level, the aggregate difference between the assumed and actual PMPM amounts for an individual MCO (across all Rating Regions and COAs) will be subject to the reconciliation.

The reconciliation process will be handled as a +/- 3% risk corridor, with no transfer of funds between 97-103% of the assumed PMPM amount, and 100% reconciliation outside of that threshold. In other words, this will be handled in a manner such that experience within 3% of the assumed crossover claims PMPM within the capitation rate (converted to dollars based on actual contract period membership) for an MCO will be at full risk (no payments or recoupments from the State). Any difference in excess of +/-3% will be fully reconciled. For example, if an MCO experiences $95 in claims, and the crossover claim amount assumed within the rates was $100, the State would recoup $2 from the MCO, and vice versa if the actual experience were higher than $103. If the MCO experiences between $97-$103, no recoupments or payments will be necessary. These thresholds mirror the percentages currently in place for the Heritage Health program-wide risk corridor.

The calculation will occur with six months of claims run out (paid through June 30, 2018), with an estimate for IBNR.

Given that the State has other risk-mitigation strategies in place for the Heritage Health program, which must be conducted within nine months of the end of CY17, the outcome of the crossover claims risk corridor will be incorporated as an adjustment to MCO revenue, prior to the calculation of the program-wide risk corridor and MLR.

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
71164 O4

PAGE	ORDER DATE
1 of 1	11/15/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

THE CONTRACT PERIOD IS:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: (813) 865-6874
E-Mail: Lauralie.Rubel@wellcare.com

(djo 04/12/16)

AMENDMENT ONE AS ATTACHED. (11/15/16 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS Division Director

Michelle Thompson 11-16-16
KS IPK 11/17/16 BUYER

11/17/16
MATERIEL ADMINISTRATOR

R43500|NISI0003|NISH0003 20150901

AMENDMENT ONE
Contract 71164 O4
Medicaid Managed Care Physical Health, Behavioral Health, and Pharmacy Services
for the State of Nebraska
Between
The State of Nebraska and WellCare of Nebraska

This Amendment (the "Amendment") is made by the State of Nebraska and WellCare of Nebraska, parties to Contract 71164 O4 (the "Contract"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the contract as follows:

I. **ADDITION:** The following section is hereby added upon execution by the parties hereto:

A. Section IV.B.4.e Retroactive Enrollment

i. For members who are enrolled with retroactive enrollment dates, the plan must establish processes for: appropriate payment of providers for services provided.
ii. Providers to request retroactive determination of medical necessity for services.
    a. Plans may only deny the retroactive request after consultation with the provider and if the plan determines that the service was not medically necessary.
iii. Reimbursement of out-of-network Medicaid providers for services provided prior to the plan selection.
iv. The plan must establish a method for waiving the claim timely filing limit if the provider submitted the claim within the State's established timely filing limit from the date of member plan selection.

B. Section IV.E.31 Continuity of Care Post Implementation

a. The plans must establish processes for continuity of care for members newly enrolled in the plan after the implementation period.

b. The plans must establish an automated process for sharing of previously approved authorizations and care management plans in which a member was enrolled. The previous plan, must respond to the request of the new plan for this information within three (3) business days.

c. The plans shall provide active assistance to members when transitioning to another Heritage Health MCO or to Medicaid FFS.

d. The receiving Heritage Health MCO shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). During this transition period, the receiving MCO shall be responsible for, but not limited to, notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

e. With the exception of transplants, for which all previous authorizations will be honored, plans will honor, regardless of provider participation network status, previous authorizations for the lesser of:

i. 30 days from the transition between Heritage Health Plans;

ii. The end date on the authorization from the previous entity; or

iii. A new decision by the plan with consultation from the provider is reached on the medical necessity of the service.

C. **Section IV.N.11.e.v.**
The MCO's must establish processes for identification of new and transferred members who have existing restricted services.

II. **REMOVAL:** The following sections are hereby removed upon execution by the parties hereto:

A. Section IV.B.2.d.
B. Section IV.P.11. State Performance Penalties

III. **MODIFICATIONS:** The following sections are hereby modified effective upon execution by the parties hereto:

A. Glossary of Terms.

Administrative cap: The upper limit a MCO may spend on non-quality improvement administrative expenses. The calculation of the administrative cap is conducted by dividing an MCO's administrative spend by the MCO's revenue. The revenue used for this calculation will be the original premium developed by the

MLTC actuary net of HIPF but gross of hold-back funds (i.e. HIPF load will be subtracted but the premium will include both earned and forfeited hold-back funds). The HIPF load is the only component removed from the premium when calculating the administrative cap.

Health care professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed mental health practitioner or licensed independent mental health practitioner, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse(including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Risk Corridor payment: Payment made by MLTC to a MCO to compensate the MCO for losses greater than the contracted amount for year one, as determined by the risk corridor calculation.

State Fair Hearing: A request by a member or any provider to appeal a decision made by a MCO, addressed to the State.

B. Section IV.B.2. Member Enrollment/Assignment

a. The MCO must comply with all enrollment and disenrollment procedures described in this section of the RFP.

b. The MCO and all its staff and subcontractors must have an understanding of the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.

c. The State maintains responsibility for the enrollment of members into MCOs through a contractual arrangement with its enrollment broker. The State or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing a MCO plan and a PCP. The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO.

d. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of an MCO. The enrollment broker is responsible for notifying all managed care enrollees and MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

e. Potential enrollees determined mandatory for managed care will be immediately enrolled in a Heritage Health Plan, retroactive to the first day of the member's eligibility for Medicaid. Retroactive enrollment into a Heritage Health Plan will not exceed three (3) months prior to month of plan selection, but in no instance shall be prior to January 1, 2017.

f. The MCO must have the technological capability and resources to interface with the State's and the enrollment broker's systems as necessary to support all aspects of the enrollment and disenrollment processes.

g. The MCO's eligibility system must show the member's effective date with the MCO as the first day of the month in which the member is determined Medicaid eligible, not to exceed three (3) months prior to the month of plan selection, but in no instance shall be prior to January 1, 2017. For example, if the State's eligibility file indicates the member was determined eligible on March 15, 2017 with a retroactive eligibility date of January 1, 2017, the MCO's eligibility system must reflect an enrollment date of January 1, 2017.

h. For current Heritage Health members at the time of the effective date of this contract, the annual enrollment choice period will be aligned with the contract start date.

i. MLTC and it enrollment broker shall make every effort to ensure that Medicaid eligible individuals who are excluded from managed care are not enrolled in a MCO. To ensure that such individuals are not assigned to a MCO, the MCO must work with MLTC or its enrollment broker to identify these individuals. The MCO must also notify MLTC if it learns that a member is no longer Medicaid eligible.

j. The enrollment broker will automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility, when the loss of eligibility does not exceed two (2) months, into the same MCO.

C. Section IV.B.4.b. ii.

Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, not to exceed

three (3) months, the effective date of enrollment may occur prior to the MCO being notified of the individual's enrollment.

D. Section IV.B.7.c.iv.

If the member's request for disenrollment is denied, the member can make a grievance or appeal to the enrollment broker.

E. Section IV.C.2.a.

All contracts must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Section 1557 of the Affordable Care Act; and the Americans with Disabilities Act. The MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

F. Section IV.E.25 Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary durable medical equipment (DME), prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.

b. The MCO must, at a minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.

c. For in-network and out-of network providers, air fluidized beds, non-standard wheelchairs and wheelchair accessories, options, and components, including power operated vehicles, and negative pressure wound therapy (wound VAC) will be reimbursed separately to the nursing facility or intermediate care facility for intellectual and developmental disabled according to the maximum allowable rate on the durable medical equipment and supplies fee schedule.

G. Section IV.L.6.e.

The MCO must educate staff members and providers of the DHHS Division of Behavioral Health Women's Set Aside program. The MCO must educate staff of the Priority Populations which include; pregnant and injecting drug users, pregnant substance abusers, injecting drug users, and women with dependent children. This may include collaboration with the Division of Behavioral Health (DBH) as appropriate.

H. Section IV.P.9. Risk Corridor

a. Annual MCO profits must not exceed 3% in the first contract year. Annual MCO profits must not exceed 2.5% in the second contract year, and annual MCO profits in subsequent contract years must not exceed 2%. MCO losses for the first contract year must not exceed 3%. In subsequent contract years, there is no limit on MCO losses.

b. Profits and losses are calculated by MLTC's actuary as a percentage of the aggregate of all qualifying revenue by the MCO and related parties, including parent and subsidy companies and risk bearing partners under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

c. This calculation must be completed within nine months of the end of the contract year. The risk corridor will be calculated first, and any payments/receipts under the risk corridor will be incorporated in the MLR calculation. This methodology is consistent with the Final Rule published by CMS.

d. If the calculation produces a profit above the indicated amount, the MCO must ensure that the surplus is deposited in the reinvestment account, as described in this section, within nine months of the end of each contract year.

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

f. If the calculation for the first contract year produces a loss of more than 3%, MLTC will make a payment to the MCO an amount equal to the loss above that amount.

g. There will be no payment under this calculation by either party for the first contract year if the calculation produces an amount between a 3% profit and a 3% loss. There will be no payment by the MCO under this calculation for the second contract year if the calculation produces an amount that does not exceed a 2.5% profit. There will be no payment by the MCO under this calculation

for any subsequent contract year if the calculation produces an amount that does not exceed a 2% profit.

I. Section IV.P.10.a

The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

J. Section IV.P.10.d

The MCO must report its performance measures that affect the MCO's eligibility to earn holdback funds monthly, quarterly, annually, and upon the request of MLTC.

K. Section IV.P.12 Administrative Cap

a. Per Neb. Rev. Stat. §71-831, the MCO's administrative spending must not exceed 12%.

b. Administrative expenditures do not include profit.

c. With its quarterly financial report, the MCO must provide to MLTC an accounting of administrative expenses.

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

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

L. Section IV.S.11.d

The MCO must ensure that its claims adjudication process only allows claims from providers with 340B Health Resources and Service Administration (HRSA) designation to carve-in Nebraska Medicaid. The MCO must have a system in place to properly identify at the claim level and transmit these claims to MLTC or its designee.

The MCO must ensure that its claims adjudication process recognizes and denies payment on 340B claims submitted by any contract pharmacy in addition to, any provider that does not have a HRSA designation carving-in Nebraska Medicaid.

M. Section IV.V.2.d. Network Performance Requirement

Between the contract award date and the contract start date, the MCO must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required sufficiency must be submitted to MLTC a minimum of forty-five (45) calendar days prior to contract start date. MLTC may assess a penalty of $1,000 per calendar day for each day that the provider network is not adequate to meet the service needs of its members.

N. Section IV.X.2 Transition Period

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

With the exception of transplants, for which all previous authorizations will be honored, MCOs will honor regardless of provider participation network status previous authorizations for the lesser of:

i. 90 days from implementation;

ii. The end date on the authorization from the previous entity; or

iii. A new decision by the plan with consultation from the provider is determined on the medical necessity of the service.

O. Attachment 11- Rates

The capitation rates for the Contractor have been adjusted for the time period of January 1, 2017 through December 31, 2017, and are set forth in the Amended Attachment 11 attached hereto and made a part hereof.

P. Vendor Contact change

Vendor Contact: Lauralie Rubel
Phone: 402-328-5402
Fax: 813-865-6874
E-mail: Lauralie.Rubel@wellkcare.com

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska
Administrative Services

By: _____

Name: Bo Botelho

Title: Materiel Administrator

Date: 11/17/16

WellCare of Nebraska

By: Lauralie M. Rubel

Name: Lauralie M. Rubel

Title: Plan President

Date: 10/27/16

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

By: _____

Name: Calder Lynch

Title: Director

Date: 11/15/16

Amended Attachment 11
Rates

Rating Region 1			
Category Of Aid	**Non-UNMC Portion of the Rate**	**UNMC Supplemental**	**Payment Rate**
AABD 00-20 M&F	$ 1,217.94	$ 28.18	$ 1,246.12
AABD 21+ M&F	$ 1,712.27	$ 31.43	$ 1,743.70
AABD 21+ M&F-WWC	$ 2,840.54	$ 113.34	$ 2,953.88
CHIP M&F	$ 189.25	$ 2.17	$ 191.42
Family Under 1 M&F	$ 703.82	$ 20.98	$ 724.80
Family 01-05 M&F	$ 155.03	$ 2.83	$ 157.86
Family 06-20 F	$ 180.20	$ 2.41	$ 182.61
Family 06-20 M	$ 197.24	$ 1.92	$ 199.16
Family 21+ M&F	$ 423.08	$ 5.84	$ 428.92
Foster Care M&F	$ 519.52	$ 7.91	$ 527.43
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,108.55	$ 201.41	$ 8,309.96
Healthy Dual	$ 333.60	$ 10.79	$ 344.39
Dual LTC	$ 275.65	$ 7.45	$ 283.10
Non-Dual LTC	$ 3,163.51	$ 72.77	$ 3,236.28
Dual Waiver	$ 324.04	$ 9.36	$ 333.40
Non-Dual Waiver	$ 1,637.27	$ 45.52	$ 1,682.79

Rating Region 2			
Category of Aid	**Non-UNMC Portion of the Rate**	**UNMC Supplemental**	**Payment Rate**
AABD 00-20 M&F	$ 1,251.17	$ 18.54	$ 1,269.71
AABD 21+ M&F	$ 1,820.84	$ 10.10	$ 1,830.94
AABD 21+ M&F-WWC	$ 3,280.01	$ 0.47	$ 3,280.48
CHIP M&F	$ 188.17	$ 1.16	$ 189.33
Family Under 1 M&F	$ 683.16	$ 16.73	$ 699.89
Family 01-05 M&F	$ 163.69	$ 0.88	$ 164.57
Family 06-20 F	$ 187.70	$ 0.92	$ 188.62
Family 06-20 M	$ 224.63	$ 1.02	$ 225.65
Family 21+ M&F	$ 512.11	$ 1.88	$ 513.99
Foster Care M&F	$ 535.16	$ 4.11	$ 539.27
Katie Beckett 00-18 M&F	$ 13,208.51	$ 100.00	$ 13,308.51
599 CHIP - Cohort	$ 398.99	$ 23.12	$ 422.11
599 CHIP - Supplemental	$ 5,280.32	$ 169.84	$ 5,450.16
Maternity	$ 8,164.11	$ 42.87	$ 8,206.98
Healthy Dual	$ 289.47	$ 2.81	$ 292.28
Dual LTC	$ 239.30	$ 1.82	$ 241.12
Non-Dual LTC	$ 2,363.84	$ 31.55	$ 2,395.39
Dual Waiver	$ 299.89	$ 3.09	$ 302.98
Non-Dual Waiver	$ 1,622.05	$ 30.33	$ 1,652.38

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
71164 O4

PAGE	ORDER DATE
1 of 1	04/12/16
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 1247761

VENDOR ADDRESS:

WELLCARE HEALTH PLANS, INC
RENAISSANCE ONE
8735 HENDERSON RD
TAMPA FL 33634-1143

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

JANUARY 01, 2017 THROUGH DECEMBER 31, 2022

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5151 Z1

Contract to supply and deliver full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to the State of Nebraska as per the attached specifications for a five (5) year period from date of award. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Troy Hildreth
Phone: (813) 206-6227
Cellular: (813) 317-0133
Fax: (813) 675-2704
E-Mail: Troy.Hildreth@wellcare.com

(djo 04/12/16)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 1	392,451,761.0000	$	1.0000	392,451,761.00
2	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 2	409,151,871.0000	$	1.0000	409,151,871.00
3	MEDICAID MANAGED CARE INITIAL CONTRACT TERM YEAR 3	426,562,697.0000	$	1.0000	426,562,697.00
	Total Order				**1,228,166,329.00**

DHHS DIVISION DIRECTOR

4/14/16 PK Michelle Thompson 4.14.16
BUYER

4/14/16
MATERIEL ADMINISTRATOR

For public information purposes only; not part of contract.

Request for Proposal Number 5151 Z1
Contract Number 71164 O4
Proposal Opening: January 6, 2016

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

WellCare of Nebraska, Inc

1. Business Continuity Plan
2. Information Technology Disaster Recovery Plan (ITDRP)

In accordance with Federal U.S. Copyright Law Title 17 U.S.C. Section 101 et seq., Title 18 U.S.C. 2319, the following material(s) has not been included due to them being copyrighted.

WellCare of Nebraska, Inc

1. Attachment B2_Moodys 2013
2. Attachment B3_Moodys 2014
3. Attachment B4_Moodys 2015
4. Attachment B5_SandP 2013
5. Attachment B6_SandP 2014
6. Attachment B7_SandP 2015
7. Attachment 31b_KY CAID Preventive Health Guide 092011
8. Attachment 31c_GA CAID OTC Brochure ENG 102014
9. Attachment 31d_GA CAID MBR Newsletter ENG 042015
10. Attachment 31e_GA CAID Prenatal Care Visit Form 2015
11. Attachment 35a_Member Newsletter
12. Attachment 35b_Mommy & Baby Matters Booklet
13. Attachment 35c_text4baby Brochure
14. Attachment 35e_Periodicity Letter
15. Attachment 47a_Provider Newsletter
16. Attachment 47b_Free Online Behavioral Therapy Notice
17. Attachment 47c_ADHD Guide for Children and Adolescents in Primary Care
18. Attachment 49a_HEDIS Online Training
19. Attachment 49b_Web Quick Guide
20. Attachment 49c_HEDIS Pediatric Quick Tips
21. Attachment 49d_Provider Services Quick Access Guide
22. Attachment 50a_Provider Resource Guide
23. Attachment 114a_Sample QIC Meeting Presentation
24. Attachment 5_Draft Member Handbook

WellCare of Nebraska, Inc. Response to
State of Nebraska
Request for Proposal (RFP) for
Full-Risk, Capitated Medicaid Managed Care Program for
Physical Health, Behavioral Health, and Pharmacy Services
RFP Number 5151 Z1

January 5, 2016

ORIGINAL: Volume 1 of 2

WellCare Health Plans

David Reynolds
Senior Vice President, Division President

January 5, 2016

Michelle Thompson & Teresa Fleming
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

Dear Ms. Thompson and Ms. Fleming:

WellCare of Nebraska, Inc. (WellCare) is pleased to submit the following proposal response to RFP Number 5151 Z1 for the purpose of providing full-risk, capitated Medicaid managed care for physical health, behavioral health, and pharmacy services to members of the Nebraska Heritage Health program.

WellCare specializes in providing managed care services exclusively to members of government-sponsored Medicaid and Medicare programs. Our clinical programs and member services focus solely on meeting the needs of these vulnerable populations, including members in urban, rural, frontier and island communities. Because of this experience, we are uniquely-positioned to meet and exceed the expectations of the Nebraska Division of Medicaid & Long Term Care (MLTC) while delivering exceptional service to the citizens of Nebraska.

Our experience and proven success coupled with our approach to meeting the contract requirements and delivering high quality care, which are detailed in the enclosed proposal, will improve quality outcomes and efficiencies across the health care delivery system. We look forward to partnering with MLTC to accomplish these improvements for Heritage Health members in Nebraska.

We welcome the opportunity to formally discuss the information provided in more detail and answer any questions that the Department of Health and Human Services and MLTC may have about our programs, capabilities, and approach. If you have any immediate questions or require further information, please do not hesitate to reach out to me directly.

Sincerely,

David Reynolds
Senior Vice President, Division President

Office Address: 1299 Farnam Street, Suite 300, Omaha, NE 68102
Telephone: 1-312-516-5944 | E-mail: david.reynolds@wellcare.com

Form A
Bidder Contact Sheet
Request for Proposal Number 5151 Z1

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

Preparation of Response Contact Information	
Bidder Name:	WellCare of Nebraska
Bidder Address:	8725 Henderson Road Tampa, FL 33634
Contact Person & Title:	Troy Hildreth, VP, Business Development Strategy
E-mail Address:	Troy.Hildreth@wellcare.com
Telephone Number (Office):	(813) 206-6227
Telephone Number (Cellular):	(813) 317-0133
Fax Number:	(813) 675-2704

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

Communication with the State Contact Information	
Bidder Name:	WellCare of Nebraska
Bidder Address:	8725 Henderson Road Tampa, FL 33634
Contact Person & Title:	Troy Hildreth, VP, Business Development Strategy
E-mail Address:	Troy.Hildreth@wellcare.com
Telephone Number (Office):	(813) 206-6227
Telephone Number (Cellular):	(813) 317-0133
Fax Number:	(813) 675-2704

REQUEST FOR PROPOSAL FORM

State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5151 Z1	**October 21, 2015**
OPENING DATE AND TIME	PROCUREMENT CONTACT
December 22, 2015 2:00 p.m. Central Time	**Michelle Thompson / Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5151 Z1 for the purpose of selecting a qualified contractor to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services.

The State of Nebraska intends to award a minimum of two (2) and a maximum of three (3) MCO contracts for the scope of work as described in Section IV. A. Program Description through Y. Termination of MCO Contract. One of the awarded contracts will also include the scope of work as described in Section IV. Z. FFS Claims Management and Processing.

Written questions for the first round of questions are due no later than November 2, 2015. Written questions for the second round of questions are due no later than November 23, 2015. Questions should be submitted via e-mail to as.materielpurchasing@nebraska.gov or may be sent by facsimile to (402) 471-2089.

The First Pre-Proposal Conference will be held on October 26, 2015 from 1:00 PM – 5:00 PM CST at Nebraska State Office Building, 301 Centennial Mall South, Lower Level, Conference Room A, Lincoln, Nebraska 68508. Bidders may call into the First Pre-Proposal Conference by utilizing the conference access number: (888) 820-1398 and attendee code: 8559164#.

The Second Pre-Proposal Conference will be held at the discretion of the State. If conducted, information will be provided at a later date.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING.**

Contractor hereby grants permission to the State of Nebraska and/or its agencies to reprint or republish any and all copyrighted documents related to Contractor's response to this Request for Proposal, and any and all figures, illustrations, photographs, charts, and other supplementary material on a website accessible by the public pursuant to Neb. Rev. Stat. §84-602.02. This waiver does not apply to proprietary information properly submitted in a separate sealed, package clearly marked "Proprietary."

Contractor represents and warrants that the contents of this response to Request for Proposal and all figures, illustrations, photographs, charts, and other supplementary material herein are original and do not libel anyone or infringe upon any patent, copyright, proprietary right, or any other right whatsoever of any other party. Contractor represents and warrants that Contractor has full power and authority to execute this Copyright Release and to grant the State of Nebraska and/or its agencies the right granted herein.

Contractor agrees to indemnify, defend, and hold harmless the State of Nebraska and/or its agencies against any and all claims, suits, and/or judgments, including costs, expenses, damages, and reasonable legal fees based upon and arising from Contractor's violation of the rights of others and/or by reason of a breach of any of the foregoing warranties.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat §73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

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

FIRM: WellCare of Nebraska, Inc.

COMPLETE ADDRESS: 1299 Farnam Street, Suite 300, Omaha, NE 68102

TELEPHONE NUMBER: 1-312-516-5944 FAX NUMBER: 1-312-516-5838

SIGNATURE: David Reynolds DATE: 12-17-15

TYPED NAME & TITLE OF SIGNER: David Reynolds, Senior Vice President, Division President

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to

award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

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

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

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

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

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

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
OR			Please note we intend to obtain E&O and Cyber liability coverage on a claims-made basis as permitted by Q&A #316.

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Sub-Contractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Sub-Contractor(s). The Contractor is also responsible for ensuring Sub-Contractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Sub-Contractor to commence work on any Sub-Contract until all similar insurance required of the Sub-Contractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

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

1. WORKERS' COMPENSATION INSURANCE

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

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

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

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

3. **REINSURANCE**

a. The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.

b. All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of 30 calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Stat. §44-3292 et seq. and other relevant laws.

c. The MCO must maintain reinsurance agreements throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.

d. The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

4. **INSURANCE COVERAGE AMOUNTS REQUIRED**

a. **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY**

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. **COMMERCIAL GENERAL LIABILITY**

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. **COMMERCIAL AUTOMOBILE LIABILITY**

Bodily Injury/Property Damage	$1,000,000 combined single limit

d. **UMBRELLA/EXCESS LIABILITY**

Over Primary Insurance	$5,000,000 per occurrence

e. **ERRORS AND OMISSIONS** $10,000,000, per occurrence

f. **CYBER LIABILITY**

Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties
$10,000,000 each occurrence / aggregate

g. **SUBROGRATION WAIVER**

"Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska."

h. **LIABILITY WAIVER**

"The State of Nebraska, Certificate holder, is an additionally insured, primary & noncontributory on the General Liability."

5. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

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

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

9. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
10. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Sub-Contractor's services, the Sub-Contractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Sub-Contractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Sub-Contractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Sub-Contractor selected to perform work on the project.

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

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

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

9. any and all employment taxes and/or other payroll withholding;
10. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
11. damages incurred by Contractor's employees within the scope of their duties under the contract;
12. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
13. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project for a period of two years after the contract implementation date.

L. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

P. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

V. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The Contractor shall use its best efforts to ensure that its employees, agents, and Sub-Contractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

X. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

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

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The contract may be terminated as follows:

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

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor.

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

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

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

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

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

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

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

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

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

   a. if directed to do so by statute;

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

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

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

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

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

   g. Contractor intentionally discloses confidential information;

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

   i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

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

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

AA. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

BB. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

DD. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The State has the option to invoke penalties as described in Section IV Project Description and Scope of Work.

EE. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The Contractor shall obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a performance bond in an amount equal to $50,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

   a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to

nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;

b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;

c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;

d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and

e. The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

FF. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not

limited to those kept by the Contractor, its employees, agents, assigns, successors, and Sub-Contractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Sub-Contractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Sub-Contractors to the extent that those sub-contracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

II. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

JJ. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Sub-Contractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

KK. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, that this RFP must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska in compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

LL. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

MM. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

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

NN. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING.**

OO. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

PP. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

QQ. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

Price information is provided under Section IV.P MCO Reimbursement.

RR. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

1. **GENERAL**
The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Sub-Contractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

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

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

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

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

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

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
DR			

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. §81-15,159.

ZZ. POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

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

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

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

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

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all sub-contracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			Not Applicable

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

EEE. LICENSE/SERVICE OR OTHER AGREEMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
JR			

Any License/Service or other such agreements which the bidder may want the State to consider must be submitted with the bid. Any License/Service or other such agreements submitted to the State post bid opening may result in

the bid being rejected in its entirety. Any such agreement, if agreed to by the State, will be considered an addendum to the contract. Any terms and conditions contained in any such accepted agreement (addendum) must not conflict with or alter the State's Terms and Conditions (Terms and Conditions) as contained in the RFP and finalized in the contract. In the event of any conflict between the Terms and Conditions and any addendum the Terms and Conditions will prevail.

The State reserves the right to reject any submitted addendum and considers the submission of any such addendum to be a proposed alteration of the Terms and Conditions.

This clause does not apply to any third party license or service agreements.

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

(under 45 CFR Part 93, Appendix A)

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

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

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

WELLCARE OF NEBRASKA, INC.

David Reynolds

Signature of Authorized Official

DAVID REYNOLDS SENIOR VICE PRESIDENT / DIVISION PRESIDENT

Name and Title of Authorized Official

12-17-15

Date

CORPORATE OVERVIEW

A. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

NAME, ADDRESS AND OTHER INFORMATION REGARDING WELLCARE OF NEBRASKA

The bidder is WellCare of Nebraska, Inc. (WellCare of Nebraska), a Nebraska corporation. Incorporated on October 20, 2015, WellCare of Nebraska is a subsidiary of WellCare Health Plans, Inc. (WellCare). WellCare of Nebraska will be the beneficiary of WellCare's broad experience serving the full array of Medicaid populations. WellCare of Nebraska's current mailing address is 1299 Farnam St, Suite 300, Omaha, Nebraska 68102. Following award, we intend to relocate our primary office to Lincoln. In addition, to ensure we are located where our members live, work and access services, we intend to open at least four Welcome Rooms, which we currently intend to locate in Kearney, Norfolk, Omaha and Scottsbluff. WellCare of Nebraska has changed neither its name nor its form of organization since it was organized.

WellCare, WellCare of Nebraska's ultimate parent company, is a Delaware corporation publicly traded on the New York Stock Exchange under the ticker symbol "WCG". WellCare's roots go back to the incorporation of WellCare of Florida, Inc. in 1985 by a group of physicians in Tampa, Florida. Originally organized as HMO Holdings, LLC on May 8, 2002, WellCare quickly changed its name to WellCare Holdings, LLC. In June 2002 WellCare purchased WellCare of Florida and The WellCare Management Group, Inc., which had operations in New York and Connecticut. In July 2004, WellCare merged into a Delaware corporation to become a corporation, changed its name to WellCare Health Plans, Inc., and completed its initial public offering of common stock.

WellCare's address is 8735 Henderson Road, Tampa, Florida 33634.

CORPORATE OVERVIEW

B. FINANCIAL STATEMENTS

The bidder must provide three years of independently audited financial statements, prepared under U.S. generally accepted accounting principles, and associated enrollment figures applicable to the firm. The bidder must also provide the last three years rating from AM Best Company; verification of any contributions made to the bidder to improve its financial position after its most recent audit (e.g. copies of bank statements and deposit slips), if applicable; and, a statement of whether the bidder or predecessor company has filed or had filed against it any bankruptcy or insolvency proceeding, and if so, relevant details. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization in the form of a letter, indicating that the bidder's business relationship with the financial institution is in positive standing.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation

WELLCARE IS AN ESTABLISHED AND FINANCIALLY SOUND COMPANY

The bidder, WellCare of Nebraska, Inc. (WellCare of Nebraska), was formed in October 2015 and therefore has no available audited financial statements. WellCare of Nebraska is a wholly-owned indirect subsidiary of WellCare Health Plans, Inc. (WellCare), an established and financially sound company whose stock is publicly traded on the New York Stock Exchange under the ticker "WCG". Please find enclosed with this proposal as **Attachment B1_WellCare 2014 Annual Report 10K** WellCare's Annual Report on Form 10-K for the year ended December 14, 2014 (the "Annual Report"), WellCare's most recent audited financial report prepared under U.S. generally accepted accounting principles. The Annual Report includes two additional years of audited financial statements for WellCare (a total of three years of independently audited financial statements). Enrollment information as of the end of each of our 2014, 2013 and 2012 fiscal years is included on page 12 of the Annual Report.

Please note that in June 2015, after the time period covered by the Annual Report, WellCare completed the offering and sale of $300 million aggregate principal amount of senior notes pursuant to a reopening of our existing series of such notes. As of September 30, 2015, WellCare had unrestricted regulated cash and investments of $1.4 billion. We are also party to a credit agreement that provides for a senior unsecured revolving loan facility of up to $300 million, which has not been drawn upon and may be used for general corporate purposes of WellCare and its subsidiaries.

As of September 30, 2015, WellCare's plans served approximately 2.4 million Medicaid and Children's Health Insurance Program (CHIP) members in nine states, including beneficiaries of Temporary Assistance for Needy Families, Supplemental Security Income, Aged Blind and Disabled and other state-based programs that are not part of the Medicaid program, such as CHIPs and Managed Long-Term Care programs. In addition, WellCare serves Medicare Advantage and Medicare Part D populations. As of

September 30, 2015, WellCare's plans served approximately 355,000 Medicare Advantage members, including dual-eligibles, and approximately one million Medicare Part D members.

WellCare focuses on providing services for government-sponsored health care programs, primarily Medicaid and Medicare. We have not been rated by the A.M. Best Company, Inc. WellCare is, however, rated by Moody's Investors Service, Inc. and Standard & Poor's Financial Services LLC. We have attached the last three years ratings from these companies as **Attachment B2_Moodys 2013**, **Attachment B3_Moodys 2014**; **Attachment B4_Moodys 2015**; **Attachment B5_SandP 2013**; **Attachment B6_SandP 2014**; **and Attachment B7_SandP 2015.**

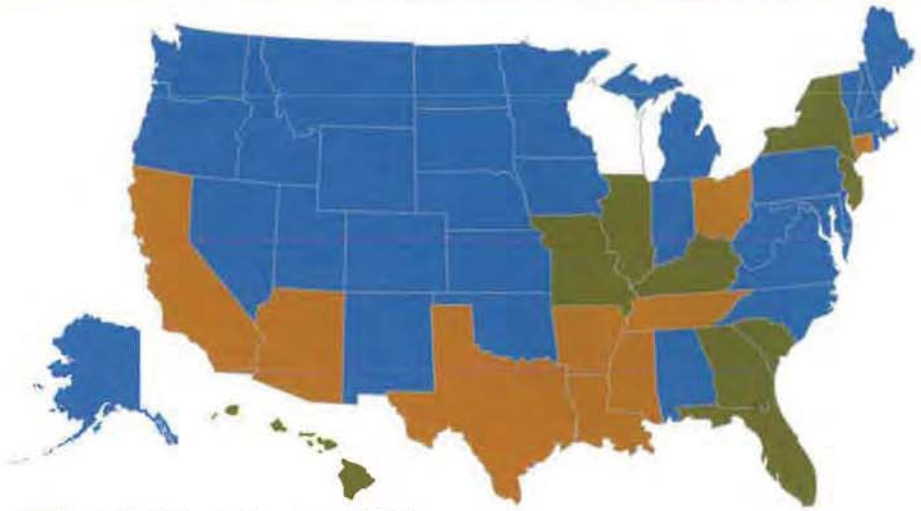
Neither WellCare of Nebraska nor WellCare, or any predecessor company of either, has filed or had filed against it any bankruptcy or insolvency proceeding.

Please find enclosed with this proposal as **Attachment B8_Wells Fargo** a letter from WellCare's banking institution, Wells Fargo, indicating that WellCare's business relationship with Wells Fargo is in positive standing and detailing the name, address and telephone number of a fiscally responsible representative of our banking organization.

To WellCare's knowledge, there are no judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of WellCare or WellCare of Nebraska.

2014 Annual Report
WellCare®
Health Plans

WellCare Health Plans, Inc. provides managed care services targeted to government-sponsored health care programs, focusing on Medicaid, Medicare and Medicare Prescription Drug Plans (PDP). Headquartered in Tampa, Florida, WellCare offers a variety of health plans for families; children; the aged, blind and disabled; and seniors. The company served approximately 4.1 million members nationwide as of December 31, 2014.



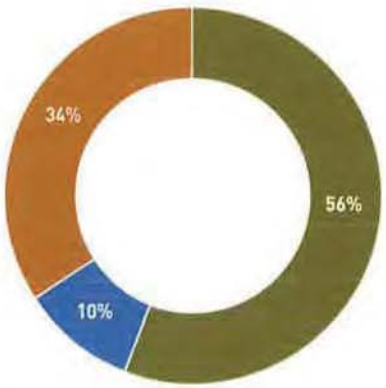
- Medicaid, Medicare Advantage, and PDP
- Medicare Advantage and PDP
- Medicare stand-alone PDP

2.3 million Medicaid members in 9 states

417,000 Medicare members in 18 states

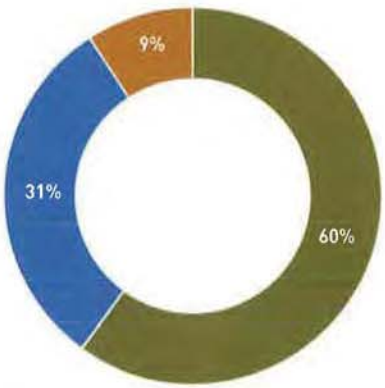
1.4 million Medicare PDP members in 49 states

Membership



Medicaid Health Plans	2,310,000
Medicare Health Plans	417,000
PDP	1,392,000
Total Membership	**4,119,000**

2014 Premium Revenue* Contribution



Medicaid Health Plans	$ 7.6 billion
Medicare Health Plans	$ 3.9 billion
PDP	$ 1.2 billion
Total Premium Revenues	**$12.7 billion**

Premium Revenue*

($ in billions)

*Excludes Medicaid state ACA industry fee reimbursement in 2014 and Medicaid premium tax revenue.

Data as of December 31, 2014

As we look forward to the coming years, we believe there are significant opportunities to build on our strengths.

KENNETH A. BURDICK
Chief Executive Officer

TO OUR STOCKHOLDERS, MEMBERS, GOVERNMENT PARTNERS, BUSINESS PARTNERS, AND ASSOCIATES:

While 2014 was a challenging year for WellCare, there were a number of seeds that were planted during the year that will bear fruit in 2015 and beyond. The actions we took in 2014 to improve our performance, combined with opportunities across all of our lines of business, give us confidence in our future.

In 2014, we made fundamental changes to our operating philosophy. We spent much of last year building a new management team by combining the best talent from within WellCare with top talent from the managed care industry. Under our new executive leadership team, we developed more rigorous processes to improve our operational and financial performance and are focused on a culture of accountability. We also began reinvesting in our associates, processes and tools to build a stronger, more enduring company. We believe this more disciplined approach, coupled with executing on our multi-year strategy that includes pursuing growth opportunities in government programs, will result in more consistent performance and margin expansion while providing value to our members, federal and state customers and provider partners.

Our focus is on government-sponsored programs—Medicaid, Medicare Advantage (MA) and Medicare Prescription Drug Plans (PDP). As of December 31, 2014, we served more than 4.1 million members across all lines of our business, growing 45 percent compared with December 31, 2013. Premium revenue of $12.7 billion for the full-year 2014 grew by 35 percent compared with the full-year 2013.*

In our Medicaid Health Plans segment, we served 2.3 million members in nine states as of December 31, 2014, growing 31 percent compared with December 31, 2013. In 2014, we successfully implemented our Florida Managed Medical Assistance Program contract to provide managed care services to Medicaid recipients in eight of 11 regions. Through this program, we added 256,000 new Medicaid members in 2014, maintaining the largest membership share in the Florida Medicaid market.

Medicaid expansion under the Affordable Care Act was also a driver of membership and revenue growth for WellCare in 2014. We currently serve the Medicaid expansion population in Hawaii, Illinois, Kentucky, New Jersey and New York, and we expect Medicaid expansion to continue to contribute to our growth in the future.

An example of one of our growth seeds is in New Jersey. WellCare began offering a Medicaid managed care product in New Jersey at the beginning of 2014, and in July 2014, we significantly expanded our presence through an acquisition of Medicaid assets in the state. We are also very pleased that in July 2014 WellCare of New Jersey received approval to participate in the state's Managed Long-Term Services and Supports program. We expect our New Jersey Medicaid business to contribute to our growth in 2015.

*Excludes Medicaid state ACA industry fee reimbursement in 2014 and Medicaid premium tax revenue.

We believe our more disciplined approach, coupled with executing on our multi-year strategy that includes pursuing growth opportunities in government programs, will result in more consistent performance and margin expansion while providing value to our members, federal and state customers and provider partners.

We also experienced strong membership and revenue growth in our Medicare Health Plans segment in 2014. Our Medicare performance in 2014 reflects a year of strong organic growth complemented by our acquisition of Windsor Health Group, Inc. in early 2014. Through this transaction, we added four new states (Arkansas, Mississippi, South Carolina and Tennessee) to our MA business and strengthened our PDP segment with new products and membership in 13 states.

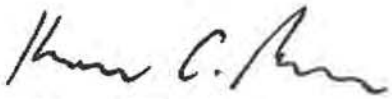
In 2014, as we looked ahead to 2015, we focused our MA bids for the 2015 plan year to balance membership with margin expansion. As part of this focus, we expect our MA membership to decline in 2015 compared with 2014, reflecting a reduction in MA membership in California due to significant benefit design changes and our exit from two counties as well as an exit from three states where we did not have meaningful scale. Overall, we anticipate that these changes will improve the financial performance of our Medicare Health Plans segment in 2015.

While our PDP segment underperformed in 2014, we believe our 2015 bid reflects a better balance between membership and margin improvement. Changes in the bid design include an increase in our basic plan premium and the introduction of deductibles. Also, in the second half of 2014, we began a major initiative to improve our pharmacy cost structure and provide greater value to our members and the federal government. As a result of this effort, in February 2015, we signed a contract with a leading pharmacy benefit management company that will be effective January 1, 2016.

As we look forward to the coming years, we believe there are significant opportunities to build on our strengths. We serve the populations that need managed care the most—the economically challenged and medically complex. Our associates are committed to our mission that includes enhancing our members' health and quality of life and partnering with providers and federal and state governments to provide quality, cost-effective health care solutions. We expect that the value proposition that WellCare has created over the past two decades will continue to be very attractive to our state and federal customers.

In closing, under our new executive leadership team, we developed a roadmap for improving our performance, and I am confident we are on the right path. The changes that we initiated last year position us for success in the years to come. We thank our associates for their hard work as we remain focused on delivering products and services that will enhance our members' health and quality of life. We look forward to continuing our long-standing relationships with our government and provider partners. We appreciate the continued support of our investors and look forward to future success.

Sincerely,



Kenneth A. Burdick
Chief Executive Officer
April 1, 2015

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the Fiscal Year Ended December 31, 2014

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the Transition Period From to

Commission File Number 001-32209

WellCare Health Plans, Inc.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**47-0937650**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
8725 Henderson Road, Renaissance One	
Tampa, Florida	**33634**
(Address of Principal Executive Offices)	(Zip Code)

(813) 290-6200
Registrant's telephone number, including area code

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
(Title of Class)	(Name of Each Exchange on which Registered)

Securities registered pursuant to Section 12(g) of the Exchange Act:
NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 of Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of Common Stock held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2014 was approximately $3.3 billion (based on the closing sale price of the registrant's Common Stock on that date as reported on the New York Stock Exchange).

As of February 13, 2015, there were 43,950,595 outstanding shares of the registrant's Common Stock, par value $0.01 per share.

Documents Incorporated by Reference: Portions of the registrant's definitive Proxy Statement for the 2015 Annual Meeting of Stockholders are incorporated by reference into Part III of this Form 10-K.

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References to the "Company," "WellCare," "we," "our," and "us" in this Annual Report on Form 10-K for the fiscal year ended December 31, 2014 (the "2014 Form 10-K") refer to WellCare Health Plans, Inc., together, in each case, with our subsidiaries and any predecessor entities unless the context suggests otherwise.

FORWARD-LOOKING STATEMENTS

Statements contained in this Form 10-K for the year ended December 31, 2014 ("2014 Form 10-K") which are not historical fact may be forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 and Section 21E of the Exchange Act, and we intend such statements to be covered by the safe harbor provisions for forward-looking statements contained therein. Such statements, which may address, among other things, our financial outlook, the timing of the launch of new programs, rate changes, market acceptance of our products and services, our ability to finance growth opportunities, our ability to respond to changes in laws and government regulations, implementation of our growth strategies, projected capital expenditures, liquidity and the availability of additional funding sources may be found in the sections of this 2014 Form 10-K entitled "*Business*," "*Risk Factors*," "*Management's Discussion and Analysis of Financial Condition and Results of Operations*" and elsewhere in this report generally. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "targets," "predicts," "potential," "continues" or the negative of such terms or other comparable terminology. You are cautioned that forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These forward-looking statements are inherently susceptible to uncertainty and changes in circumstances, as they are based on management's current expectations and beliefs about future events and circumstances. Given the risks and uncertainties inherent in forward-looking statements, any of WellCare's forward-looking statements could be incorrect and investors are cautioned not to place undue reliance on any of our forward-looking statements. Subsequent events and developments may cause actual results to differ, perhaps materially, from WellCare's forward-looking statements. We undertake no obligation beyond that required by law to update publicly any forward-looking statements for any reason, even if new information becomes available or other events occur in the future.

Our actual results may differ materially from those indicated by forward-looking statements as a result of various important factors including the expiration, cancellation, suspension or amendment of our state and federal contracts. In addition, our results of operations and estimates of future earnings depend, in large part, on accurately estimating and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in health care practices, changes in the demographics of our members, higher than expected utilization of health care services by our members, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, changes in or suspensions or terminations of our contracts with government agencies, new technologies, such as new, expensive hepatitis C medications, potential reductions in Medicaid and Medicare revenue, government-imposed surcharges, taxes or assessments, changes to how provider payments are made by governmental payors, the ability of state customers to launch new programs on their announced timeline, major epidemics, disasters and numerous other factors affecting the delivery and cost of health care, such as major health care providers' inability to maintain their operations and our ability to implement medical expense initiatives and our ability to control our medical costs and other operating expenses, including through our vendors, may affect our premium revenue, medical expenses, profitability, cash flows and liquidity. Governmental action or inaction could result in premium revenues not increasing to offset any increase in medical costs, the Affordable Care Act ("ACA") industry fee or other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods generally cannot be recovered through higher premiums. Furthermore, if we are unable to estimate accurately incurred but not reported medical costs in the current period, our future profitability may be affected. Due to these factors and risks, we cannot provide any assurance regarding our future premium levels or our ability to control our future medical costs.

In addition, the risks and uncertainties include, but are not limited to, our progress on top priorities such as improving health care quality and access, ensuring a competitive cost position, delivering prudent, profitable growth, and achieving service excellence, our ability to effectively estimate and manage growth, our ability to address operational challenges relating to new business, our ability to effectively execute and integrate acquisitions, and the performance of our acquisitions once acquired. Due to these factors and risks, we may be required to write down or take further impairment charges of assets associated with acquisitions. Furthermore, at both the federal and state government levels, legislative and regulatory proposals have been made related to, or potentially affecting, the health care industry, including but not limited to limitations on managed care organizations, including changes to membership eligibility, benefit mandates, and reform of the Medicaid and Medicare programs. Any such legislative or regulatory action, including changes to membership eligibility, benefit mandates or reform of the Medicaid and Medicare programs, could have the effect of reducing the premiums paid to us by governmental programs, increasing our medical and administrative costs or requiring us to materially alter the manner in which we operate. We are unable to predict the specific content of any future legislation, action or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect or ramifications of such future legislation, action or regulation on our business. We also may be unable to comply with the terms of our Corporate Integrity Agreement, which could result in monetary penalties or exclusion from participating in federal health care programs.

PART I

Item 1. Business.

OVERVIEW

We are a leading managed care company for government-sponsored health care coverage with a focus on Medicaid and Medicare programs. Headquartered in Tampa, Florida, we offer a variety of managed care health plans for families, children, and the aged, blind and disabled, as well as prescription drug plans. As of December 31, 2014, we served approximately 4.1 million members in 49 states and the District of Columbia. We estimate that we are among the ten largest Medicaid providers of managed care services plans, and among the ten largest providers of Medicare Advantage ("MA") plans and prescription drug plans ("PDPs"), all as measured by membership. We believe that our broad range of experience and exclusive government focus allows us to effectively serve our members, partner with our providers and government clients, and efficiently manage our ongoing operations.

We were formed as a Delaware limited liability company in May 2002 and began our operations in Florida, New York and Connecticut. We completed the acquisition of these health plans through two concurrent transactions in July 2002. In July 2004, immediately prior to the closing of our initial public offering, we merged the limited liability company into a Delaware corporation and changed our name to WellCare Health Plans, Inc.

As of December 31, 2014, we operated Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, New Jersey, New York and South Carolina. In addition, we offered MA coordinated care plans ("CCPs") in certain counties in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Mississippi, Missouri, New Jersey, New York, Ohio, South Carolina, Tennessee and Texas. We also offered stand-alone Medicare PDPs in 49 states and the District of Columbia. Effective January 1, 2014, as a result of our acquisition of Windsor Health Group, Inc. ("Windsor"), we began serving MA members in certain counties in Arkansas, Mississippi, South Carolina and Tennessee, as well as offering Medicare Supplement plans in 39 states. See further discussion below under "Acquisitions". Effective January 1, 2015, we no longer offer MA plans in the states of Arizona, Missouri and Ohio.

As of December 31, 2014, our Medicare plans are offered under the WellCare name, for which we hold a federal trademark registration, with the exception of our Hawaii CCP, California CCP, and Arizona CCP, which we offer under the names 'Ohana, Easy Choice and Desert Canyon Community Care, respectively. Additionally, through December 31, 2014, our Medicare plans in Arkansas, Mississippi, South Carolina and Tennessee attributable to the Windsor acquisitions were offered under the Windsor name, however, effective January 1, 2015, these plans were rebranded as WellCare MA plans. For our Medicaid plans, we offer a number of brand names depending on the state, consisting of the Staywell and HealthEase brand names in Florida, the 'Ohana brand name in Hawaii, the Harmony brand name in Illinois, the Missouri Care brand name in Missouri and the WellCare brand name in Georgia, Kentucky, New Jersey, New York and South Carolina.

We manage our business with three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs. See **Our Product Segments** below for further discussion.

Membership Concentration

In the following table, we have summarized membership for our business segments in each state that exceeded 5% of our total membership, as well as all other states in the aggregate, as of December 31, 2014.

State	Medicaid Health Plans	Medicare Health Plans	Medicare PDPs	Total Membership	Percent of Total Membership
Florida	**722,000**	**104,000**	**62,000**	**888,000**	**21.6%**
Georgia	604,000	33,000	55,000	692,000	16.8%
Kentucky	**420,000**	**5,000**	**21,000**	**446,000**	**10.8%**
New York	116,000	52,000	59,000	227,000	5.5%
Illinois	**161,000**	**15,000**	**43,000**	**219,000**	**5.3%**
All other states (1)	287,000	208,000	1,152,000	1,647,000	40.0%
Total	2,310,000	417,000	1,392,000	4,119,000	100.0%

(1) Represents the aggregate of all states that individually have less than 5% of total membership.

Acquisitions

On January 1, 2014, we acquired all of the outstanding stock of Windsor from Munich Health North America, Inc., a part of Munich Re Group. Through its subsidiaries, Windsor serves Medicare beneficiaries with MA, PDP and Medicare Supplement products. As of December 31, 2014, Windsor offered MA plans in 192 counties in the states of Arkansas, Mississippi, South Carolina and Tennessee, through which it served 37,000 members. In addition, one of Windsor's subsidiaries offers Medicare Supplement insurance policies through which it served 43,000 members in 39 states as of December 31, 2014. Windsor also offers PDPs in 11 of the 34 Centers for Medicare & Medicaid Services ("CMS") regions, through which it served approximately 103,000 beneficiaries as of December 31, 2014. We included the results of Windsor's operations from the date of acquisition in our consolidated financial statements.

Effective July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst Health Plans of New Jersey, Inc., ("Healthfirst NJ"). The acquired assets primarily relate to approximately 42,000 Healthfirst NJ Medicaid members who were transferred to our Medicaid plan in New Jersey on July 1, 2014, as well as to certain provider agreements, which transferred to us. Prior to the acquisition, we began offering Medicaid managed care in Essex, Hudson, Middlesex, Passaic and Union counties in New Jersey effective January 1, 2014. As a result, effective July 1, 2014, we offered Medicaid managed care in 10 counties in New Jersey.

OUR VISION AND STRATEGY

We operate exclusively within government-sponsored health care programs, offering Medicare, Medicaid and Medicaid-related health plans that serve the full spectrum of eligibility groups, with a focus on lower-income beneficiaries. We are committed to operating our business in a manner that serves our key constituents – members, providers, government customers, and associates – while delivering competitive returns for our investors.

Vision

Our vision is to be the leader in government-sponsored health care programs in partnership with the members, providers, governments and communities we serve.

Mission

Our primary mission is to:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Our advantage is that we focus on serving Medicaid and Medicare members - we understand their special needs and challenges, and know the communities they live in well. We have developed a full complement of expertise in the three major areas of government-sponsored health care: Medicaid, Medicare and Medicare Prescription Drug Plans.

A key driver of our performance has been our three-product strategy: leveraging the complementary aspects of our meaningfully scaled positions in Medicaid, MA, and PDPs in order to generate better results from each program than we would were we serving only one program. We believe the strategy enhances our revenue growth because we have multiple product and program opportunities by which we can enter a new state or service area. Once established in a market, our ability to expand into other products is strengthened by the existence of our provider network, service infrastructure, and regulatory relationships. With respect to costs, offering multiple products within a service area better leverages our local investments and infrastructure, including our provider network, community support, regulatory relationships, and staffing. Providing a more comprehensive set of services not only reduces our costs associated with obtaining members, it also provides a better care experience for our members. Finally, the three-product strategy drives greater diversification of sources of revenue and earnings, and, consequently, a stronger and more stable capital position from which to serve our government customers, members, and business partners.

A natural extension of our three-product strategy is our focus on serving lower income individuals and those who are dually eligible for Medicaid and Medicare. Our provider network, community support relationships, service infrastructure, and other important elements of our business model all are targeted to serving Medicaid eligibles and Medicare eligibles who may be economically disadvantaged. This focus, combined with significant expected growth in these programs, offers us a sizable opportunity to meet the needs of a generally underserved market and further differentiates us from other managed care companies.

Aligned with our business strategy are four long-term business priorities:

- Improve health care quality and access;
- Optimize financial performance;
- Deliver prudent, profitable growth; and
- Achieve service excellence.

Improve health care quality and access

We are committed to continually improving the quality of care and service that we provide to our members, and to help them access the right care at the right time in the appropriate setting. We work closely with our provider partners and government customers to further enhance health care delivery and improve the quality of, and access to, health care services for our members. We are focused on preventive health, wellness and care management programs that help our government customers provide quality care within their fiscal constraints and offer us long-term opportunities for prudent, profitable growth. Our investments in quality have led to improvement in our results. Since 2010, we have achieved accreditation by the National Committee for Quality Assurance ("NCQA") for our health plans in Florida, Georgia, Hawaii, Kentucky, Missouri and South Carolina. Our goal is to achieve accreditation for all of our health plans. CMS recently announced 2015 MA and PDP quality ratings, also known as "Star Ratings", which reflected improvement for several of WellCare's plans. Based on Star Ratings recently reported by CMS, 95% of our December 31, 2014 MA membership will be served in a plan rated three stars or better on an overall basis for 2015.

Optimize financial performance

As both a government contractor and a publicly-held company, we have an obligation to be good stewards of our premiums, income and other financial resources. We strive to align our expense structure with our revenue base and continually assess opportunities to maintain appropriate medical benefit ratios, contain administrative costs, generate earnings that enable us to re-invest in our business, and provide an attractive rate-of-return to our shareholders. We also continue to invest in technology, regulatory compliance, and other infrastructure with the objective, among others, of improving efficiency and service quality. As a result of initiatives and investments, we have achieved meaningful improvement in our operating efficiency and leveraging of our fixed costs. During 2014, we increased our investment in infrastructure to drive efficiency. Our administrative expense ratio, excluding government investigation-related expenses, has decreased from 10.6% in 2010 to 7.7% in 2014, or 290 basis points. With respect to medical benefits expense, our initiatives are focused on reductions in unit costs as well as optimizing utilization of services and eliminating waste and abuse for medical and pharmacy services and products.

Deliver prudent, profitable growth

We pursue opportunities for prudent, profitable growth through an approach we define as "bid, build, and buy," deploying a combination of organic growth activities supplemented by acquisitions. Bidding includes Medicaid procurements of new and existing programs, as well as annual bids for PDPs and similar activities. Growth through "building" is focused on creation of the marketing, network, community support, and other capabilities required to expand organically into new service areas. Since 2012, acquiring businesses with important market and/or product positions has supplemented our organic growth. These bid, build, and buy initiatives have resulted in a 138% increase in our total premium revenues from $5.4 billion in 2010 to $12.9 billion in 2014.

Achieve service excellence

WellCare's "mission to serve" starts with our members, but it does not end there. We are committed to continually helping our members access the right care at the right time in the appropriate setting; partnering with providers to improve outcomes and quality; and serving our government customers via quality, cost-effective health care solutions. We seek to instill a culture of service in everything we do, both internally and externally.

From our headquarters in Tampa, we manage our shared services operations, which primarily handle high volume transactions that lend themselves to centralized management and provide scale efficiencies. These functions include customer service, claims processing, and utilization management, among other operations. Our shared services operations are complemented by our local market management. In each of the states in which we operate a sizable health plan, we have a market leader who manages customer-facing functions such as member outreach, provider and quality management, and state government relations. Through this model, we adapt our shared services platform to meet the specific needs of each market and customer that we serve. This approach enables us to provide access to high quality for our members and culturally sensitive health care services.

For a list of key developments and accomplishments relating to progress on our strategic business priorities that occurred or impacted our financial condition and results of operations during 2014, and in the 2015 period prior to issuance of this 2014 Form 10-K, please see Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations, *Key Developments and Accomplishments*.

OUR BUSINESS - MEDICARE AND MEDICAID HEALTH PROGRAMS

Government-sponsored coverage is an important element of the United States' health care system. According to CMS, federal and state spending on Medicaid, Children's Health Insurance Programs ("CHIPs"), and Medicare is expected to have exceeded $1.0 trillion and aided over 125 million people in 2014. By 2024, CMS anticipates spending on these three programs to increase by 85%. Managed care solutions have a well-established track record of helping governments improve health care quality and access for beneficiaries while strengthening the fiscal sustainability of these programs. Given economic conditions, demographics, budget challenges, and the proven success of managed care programs, we believe state governments and the federal government will continue to turn to managed care solutions to help achieve program objectives.

A "managed care" plan is an integrated health care delivery system that manages health care services for an enrolled population rather than simply providing or paying for them. Services within managed care plans are usually delivered by providers who are under contract to, or employed by, the plan. Managed care plans use a variety of approaches to "manage" care, including care management, capitation, risk-sharing or incentive-based arrangements with providers, the use of primary care physicians to act as primary care gatekeepers and the use of preferred provider networks.

The Congressional Budget Office ("CBO") estimated that in 2014, approximately 61 million people were covered by the joint state and federally funded Medicaid program and approximately 54 million people were covered by the federally funded Medicare program. Of these, approximately 9 million people were dual-eligibles.

Medicare

The 1965 amendments to the Social Security Act created the Medicare program, which provides health care coverage primarily to individuals age 65 or older as well as to individuals with certain disabilities. The Medicare program consists of four parts, labeled A through D. Part A provides hospitalization benefits financed largely through Social Security taxes and requires beneficiaries to pay out-of-pocket deductibles and coinsurance. Part B provides benefits for medically necessary services and supplies including outpatient care, physician services, and home health care. Beneficiaries enrolled in Part B are required to pay monthly premiums and are subject to annual deductibles. Parts A and B are referred to as "Original Medicare."

Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly HMOs, as an alternative to Original Medicare. This program is referred to as Medicare Part C. The Balanced Budget Act of 1997 named Medicare's managed care program "Medicare+Choice," and in 2003 under the Medicare Prescription Drug, Improvement and Modernization Act (the "MM Act"), the private health plan program was renamed Medicare Advantage. In geographic areas where a managed care organization has contracted with CMS pursuant to the MA program, Medicare beneficiaries may choose to receive benefits from an MA organization under Medicare Part C. Private plans provide benefits to enrollees that are at least comparable to those offered under Original Medicare and can include prescription drug coverage and supplemental benefits. Part C benefits are provided through HMOs, preferred provider organizations and private fee-for-service plans. MA plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits.

The MM Act also established Medicare Prescription Drug Coverage, or Part D, in 2003. Effective January 1, 2006, stand-alone PDP plans could be offered to individuals eligible for benefits under Part A and/or enrolled in Part B. Plans can include varying degrees of out-of-pocket costs for premiums, deductibles and coinsurance. Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forgo Part D drug coverage. Beneficiaries enrolled in Medicare Advantage Plans can join a plan with Part D coverage, select a stand-alone PDP or forgo Part D coverage. Beneficiaries who are dually-eligible for Medicare and Medicaid, and certain beneficiaries who qualify for the low-income subsidy ("LIS"), but do not enroll themselves in an MA plan with drug benefits or a PDP, are automatically assigned to a plan by CMS. These assignments are made among those PDPs that submitted bids below the applicable regional benchmarks for standard Part D plans.

Medicare Supplement policies were first introduced in 1971 as additional coverage for some of the cost sharing requirements of Original Medicare. The standardization of these Medicare Supplement plans began with the passing of the Social Security Disability Amendments of 1980, which set voluntary standards for the Supplement plans. The Omnibus Reconciliation Act of 1990 further standardized the plans by limiting them to standard benefit structures while adding several consumer protections such as guaranteed plan renewability and minimum loss ratios among others. To be enrolled in a Medicare Supplement plan, an individual must pay a monthly plan premium. Depending on the plan type selected, the Medicare Supplement plan pays all or a part of the cost sharing amount for health care services that the individual received while covered under Original Medicare. In 2012, Medicare Supplement plans covered approximately 10.2 million people.

According to CMS, Medicare expenditures have increased from $225 billion in 2000 to an estimated $586 billion in 2013 and are anticipated to further increase to $1 trillion in 2021. The number of Medicare beneficiaries is expected to grow from 53 million in 2014 to 61 million in 2019. In 2014, approximately 30% of Medicare beneficiaries, or 15.7 million people, were enrolled in an MA plan, and 23.3 million were enrolled in PDPs.

Medicaid

Medicaid was established by the 1965 amendments to the Social Security Act of 1935 as a joint federal-state program to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Within federal guidelines, each state may define its own package of covered medical services, resulting in considerable variation in the types of services covered and the amount of care provided across states. Many states offer a variety of public health insurance programs for low-income residents, including Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") as well as other state-based programs that are not part of the Medicaid program, such as CHIP and Managed Long-Term Care ("MLTC") programs. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP programs provide assistance to qualifying families who are not eligible for Medicaid because their income exceeds the applicable income thresholds. See further discussion below under "*Children's Health Insurance Program (CHIP)*". MLTC programs are designed to help people with chronic illnesses or who have disabilities and need health and long-term care services, such as home care or adult day care, to enable them to stay in their homes and communities as long as possible.

Macroeconomic conditions in recent years have, and are expected to continue to, put pressure on state budgets as the Medicaid eligible population increases, creating more need and competition for funding with other state priorities. As Medicaid consumes more and more of the states' limited dollars, states must either increase their tax revenues or reduce their total costs. Since states are limited in their ability to increase their tax revenues, states often look to reduce costs by reducing funds allotted for Medicaid or finding ways to control rising Medicaid costs, which may include reducing premium rates or imposing further restrictions on beneficiary eligibility. We believe that one of the most effective ways to control rising Medicaid costs is through managed care.

States have traditionally provided Medicaid benefits using a fee-for-service system. However, states are now more frequently implementing a managed care delivery system for Medicaid benefits. In a managed care delivery system, beneficiaries get most or all of their Medicaid services from a managed care plan or other type of organization under contract with the state. According to the Kaiser Family Foundation, only 12 states do not have some form of Medicaid managed care. With the passage of health care reform legislation (as discussed below), certain states have expanded coverage under the Medicaid program to an estimated 7 million additional beneficiaries in 2014, which will increase to 13 million additional beneficiaries in 2022, according to the CBO. Expansion of Medicaid is likely to increase the number of people enrolled in and the amount of spending for managed care. Accordingly, the opportunity for growth in managed care may be significant.

According to CMS, federal and state spending on Medicaid and CHIP has increased from $203 billion in 2000 to an estimated $521 billion in 2014, and is forecasted to grow to $730 billion in 2019. The population aided by these programs is anticipated to increase from 72 million in 2013 to 84 million in 2019.

Children's Health Insurance Program (CHIP)

We provide services under the CHIP program in eight states. In some states, like Hawaii, those beneficiaries are served as a part of the state's Medicaid program. These CHIP programs are referred to as expansion programs. In other states, including New York and Florida, the state's CHIP program is operated separately. The New York program is referred to as Child Health Plus, the Florida program is referred to as the Florida Healthy Kids program. The CHIP program was established in 1997 to serve low income, uninsured children. In some states, the program was extended to the parents of those children. As a result of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), parents previously covered under CHIP may now instead be covered through the state's Medicaid expansion or may be eligible for premium assistance and other subsidies through the state or federal exchange, as applicable. The ACA maintained the CHIP eligibility standards for children in place as of enactment through 2019 and extended CHIP funding until September 30, 2015.

Dual-eligibles

Individuals qualifying for both Medicare and Medicaid are referred to as "dual-eligibles". For dual-eligibles, if a service is covered by Medicare and Medicaid, Medicare is the primary payer. Medicaid pays for services above and beyond what Medicare covers, which is often referred to as wrap-around coverage. Medicaid may also cover some beneficiary cost-sharing associated with Medicare services beneficiaries require. For Medicaid benefits that are not covered by Medicare, such as certain

long-term care services, Medicaid covers the cost of these benefits unless there is another liable third-party payer. Medicaid is generally the payer of last resort. The Medicare and Medicaid services that dual-eligibles receive do not blend seamlessly with one another. The programs often have different eligibility requirements or scope of coverage for the same (or similar) services. Fragmentation can result in providers lacking information about the full range of services that their patients receive, which could compromise health care decision-making; beneficiary confusion; cost inefficiencies in Medicare and Medicaid; and poorer quality of care and health care outcomes for the beneficiary.

Improved care coordination is imperative to enhance care options for dual-eligibles as an aging population and increased life expectancy among Americans with disabilities increase the dual-eligible population. As such, dual-eligible programs have become an immediate target for both spending reductions and attempts to improve the quality of care beneficiaries receive. The ACA created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state Duals Demonstration Programs intended to provide better coordination and integration of care between Medicare and Medicaid on a capitated or fee for service basis, which is required to produce cost savings.

Nine states are implementing a capitated Duals Demonstration Program; one state is implementing a Duals Demonstration Program on a fee-for-service basis and one state is doing both. Of the states that have signed agreements with CMS to implement a capitated Duals Demonstration Program, we operate dual special needs plans ("D-SNPs") in six. We began participation in the Duals Demonstration Program in New York on January 1, 2015. Other states in which we operate, including Florida and Tennessee, are working toward greater integration of their Medicare and Medicaid programs outside of a demonstration program.

For those states in which we offer a D-SNP that have a Duals Demonstration Program in which we do not participate, the membership in our MA or PDPs could be reduced, depending on the program design, eligible populations and state implementation time frame.

Health Insurance Exchanges

Effective January 1, 2015, we began offering individual health plans in New York and Kentucky through state-based exchanges.

General Economic and Political Environment Impacting our Business

The U.S. health care economy currently comprises approximately 17% of the U.S. gross domestic product, according to CMS. We expect overall spending on health care in the U.S. to continue to rise due to inflation, evolving medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the U.S. population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms, which could also impact our results of operations.

We expect that the state and federal governments will continue to look for budgetary cost control savings through reductions in health care costs. We may also experience delays in premium payments from our state customers. The "maintenance of effort" requirements under the ACA generally prohibit states from restricting Medicaid eligibility or tightening enrollment procedures. These provisions were phased out for adults effective January 1, 2014 and will phase out for children in 2019.

Pursuant to the sequestration provisions of the Budget Control Act of 2011, approximately $1.2 trillion in domestic and defense spending reductions began in March 2013. Effective April 1, 2013, payments to MA and PDP plans were reduced by 2%. On December 26, 2013, President Obama signed into law the Bipartisan Budget Act of 2013, which provided that the 2% sequestration reduction to Medicare provider and plan payments continue in 2014 and extended the payments for two additional years through 2023. We have been able to partially offset this impact by a reduction in reimbursements to health care providers; however, our 2013 and 2014 results of operations were negatively impacted. The Bipartisan Budget Act of 2013 also funded Medicare, Medicaid and CHIP for fiscal year 2014.

On April 1, 2014, the President signed the Protecting Access to Medicare Act of 2014. This Act delayed until March 2015 the 24% reduction in Medicare payment rates that was supposed to take effect on April 1, 2014, as a result of the sustainable growth rate formula and replaced it with a 0.5% increase in payments through December 31, 2014. Unless further Congressional action is taken, the sustainable growth rate formula will reduce Medicare payment rates by 24% beginning April 1, 2015. The Act also delayed the implementation of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) prohibiting the Secretary of Health and Human Services from adopting the ICD-10 code sets prior to October 1, 2015. The ICD-10 code sets have required substantial investments from health care organizations, including us. We may experience complications related to supporting providers that are not fully compliant and if providers fail to provide appropriate codes for services as a result of the new coding set, we may not be adequately reimbursed for such services.

If the sustainable growth rate formula cuts are imposed, the cuts could have a significant impact on health care provider willingness to participate in Medicare programs. Congress is working towards a permanent fix to this issue, but has not yet appropriated funds for these payments for the remainder of 2015 and may fail to do so.

In addition, in 2015, the government will once again hit the debt ceiling, most likely in August. Action or inaction by Congress on the sustainable growth rate, the debt ceiling or budget issues could have a material adverse impact on our results of operations or cash flows.

Congress has proposed several plans to cut or restructure Medicare including raising the Medicare eligibility age, moving Medicare to a defined contribution model, and various modifications including cuts to provider reimbursement. Medicaid is similarly situated, consuming ever greater portions of the federal budget. As a result, several proposals have been suggested to modify the Medicaid program including moving from a match program to a block grant, moving to a per-capita capitation system, and limiting the use of provider taxes to fund the state's portion of the Medicaid program. We do not know whether any of these proposals will pass or the impact any ultimate reform will have on our business.

Health Care Reform

In March 2010, the ACA became law and significantly reformed various aspects of the U.S. health insurance industry. Financing for these reforms comes in part from substantial additional fees and taxes on us and other health insurers, health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare. While regulations and interpretive guidance on some provisions of the ACA have been issued to date by the Department of Health and Human Services ("HHS"), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners ("NAIC"), there are many significant provisions of the legislation that continue to be revised and modified by additional guidance and clarification in the form of regulations and interpretations. As a result, it is difficult to estimate the impact of this legislation on our overall business, which we expect to occur over the next several years.

The ACA included a number of changes that could impact the way MA plans operate, such as:

- ***Reduced Medicare Premium Rates.*** On April 7, 2014, CMS revised their proposed 2015 rates, which we estimate will result in a rate decrease in the low single digit percentage from our 2014 rates. In addition to the 2% sequestration cut, 2014 benchmark rates resulted in a decrease of between 2.0 to 4.0% and a further risk coding intensity reduction of 4.91% compared to 2013 rates.

- ***CMS Star Ratings.*** Certain provisions in the ACA tie MA premiums to the achievement of Star Ratings. Beginning in 2015, MA plans with an overall Star Rating of four or more stars will be eligible for a quality bonus in their basic premium rates. None of our plans are four stars, so we will not receive a quality bonus. Plans that receive quality bonuses may have a competitive advantage in the Medicare market, as they may be able to offer more attractive benefit packages to members and/or achieve higher profit margins. Also, beginning with open enrollment for the 2014 plan year, Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years have been excluded from mention in the CMS "Medicare and You" handbook, denoted as "low performing" plans on the CMS website, and excluded from on-line enrollment through the Medicare Plan Finder website. These actions may adversely impact these plans' ability to maintain or increase membership. CMS could exercise its authority and terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2016. Our MA plans in Louisiana and our Windsor MA plans, representing approximately 47,000 members as of January 1, 2015, could be terminated effective December 31, 2015 if their Part C and Part D star ratings are not at least three stars for the plan year 2016. We serve a larger percentage of D-SNP members than our competitors, and this population is more challenging to serve. CMS's quality measurement methodology does not account for population differences between plans, and therefore, we may be unable to achieve a four star rating for some or all of our plans. While we are continuing efforts to improve our Star Ratings and other quality measures, there is no guarantee that we will be able to maintain or improve our Star Ratings.

- ***Minimum Medical Loss Ratio ("MLR").*** Beginning in 2014, the ACA requires the establishment of a minimum MLR for MA and Part D plans, requiring them to spend not less than 85% of premiums on medical and pharmacy benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. The MLR prescribed by HHS differs from the MLR calculated under accounting principles generally accepted in the United States of America ("GAAP") and is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions have not had a material impact to our results of operations in 2014.

Under the ACA, over a 10-year period beginning in 2010, the "coverage gap" (i.e., the dollar threshold at which an individual has to pay full price for his or her medications) under Part D has been gradually closing, with beneficiaries retaining a 25% co-pay in 2020. While this change will ultimately result in increased insurance coverage for beneficiaries, such improved benefits could result in changes in member behavior with respect to drug utilization. Such actions could impact the cost structure of our PDPs.

In April 2014, CMS also announced changes for PDPs relating to applicable beneficiary and plan dispensing/vaccine administration fees for drug claims that straddle the coverage gap for the 2015 plan year. In addition, CMS increased the Part D deductible, the initial coverage limit, and the out-of-pocket threshold for the catastrophic benefit. CMS also approved several extremely high cost drugs during 2014, and may do so in 2015 as well.

The health reforms in the ACA present both challenges and opportunities for Medicaid plans. The reforms allow states to expand the eligibility for Medicaid programs. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the net impact of the ACA will be positive or negative for Medicaid plans.

Additionally, the ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers which began in 2014. The total ACA industry fee levied on the health insurance industry was $8 billion in 2014 and will be $11.3 billion in 2015, with increasing annual amounts thereafter, growing to $14.3 billion by 2018. After 2018, the industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S. health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. We incurred $137.7 million of such fees in 2014 and currently estimate that we will incur between $230 and $235 million in such fees in 2015, due to the increase in the total fee to be levied on the industry and the expected increase in our share of total 2014 industry premiums. However, the 2015 final fee amount will not be determined until August 2015. We have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014. We have also obtained similar commitments from our Medicaid customers for 2015. CMS does not directly reimburse us for the impact of the ACA industry fee related to MA and PDP premiums.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the provisions in the ACA requiring most Americans meeting certain income qualifications to purchase health insurance meeting certain standards or to pay a financial penalty ("the individual mandate"). The Supreme Court made the expansion of the states' Medicaid programs to individuals with incomes up to 133% of the federal poverty line optional for states.

We currently serve the Medicaid expansion population in Hawaii, Illinois, Kentucky, New Jersey and New York. Our other Medicaid states, Florida, Georgia, Missouri and South Carolina, have not expanded their Medicaid eligibility. If other states ultimately implement the Medicaid expansion, and depending on the mechanism by which they choose to implement the expansion, our membership could increase or decrease. At this time, we are unable to predict the ultimate impact to our Medicaid membership.

In 2014, we did not participate in the health insurance exchange products, however, for 2015, we are participating in Kentucky's and New York's state exchanges. Individuals who select an exchange product other than ours or where we do not offer one, and subsequently become eligible for a Medicaid plan that we offer, may be less likely to select or be assigned to us.

Interpretive guidance continues to be issued on several significant provisions of the ACA. Given the breadth of possible changes and the uncertainties of interpretation, implementation and timing of these changes, which we expect to occur over the next several years, the ACA could change the way we do business, potentially impacting our pricing, benefit design, product mix, geographic mix, and distribution channels. The response of other companies to the ACA and adjustments to their offerings, if any, could have a meaningful impact on the health care markets. Further, various health insurance reform proposals are also emerging at the state level. It is reasonably possible that these changes, as well as future legislative changes, in the aggregate, may have a material adverse effect on our results of operations, financial position, and cash flows by restricting revenue, enrollment and premium growth in certain products and market segments; restricting our ability to expand into new markets; increasing our medical and administrative costs; lowering our Medicare payment rates and/or increasing our expenses associated with the non-deductible federal premium-based assessment and other assessments.

OUR PRODUCT SEGMENTS

Our operations are conducted in three business segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs, which correspond with the Medicaid and Medicare products that we offer. Prior to the Windsor acquisition on January 1, 2014, we identified three operating segments for our company: Medicaid, MA and PDP. In conjunction with the Windsor acquisition, we began offering Medicare Supplement products and we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of Medicare Supplement and MA operations acquired as part of the Windsor acquisition together with our legacy MA plans. Accordingly, we include results for Medicare Supplement operations together with MA and renamed the segment as Medicare Health Plans. Similarly, we include the PDP operations acquired as part of the Windsor acquisition together with WellCare's PDPs and renamed the segment as Medicare PDPs. In addition, we renamed the Medicaid segment Medicaid Health Plans; however, there were no changes to the composition of this segment.

Membership by segment, and as a percentage of consolidated totals, is as follows.

	For the Years Ended December 31,					
	2014		2013		2012	
Segment	Membership	Percentage of Total	Membership	Percentage of Total	Membership	Percentage of Total
Medicaid Health Plans	**2,310,000**	**56.1%**	**1,759,000**	**61.8%**	**1,587,000**	**59.5%**
Medicare Health Plans	417,000	10.1%	290,000	10.2%	213,000	8.0%
Medicare PDPs	**1,392,000**	**33.8%**	**797,000**	**28.0%**	**869,000**	**32.5%**
Total	4,119,000	100.0%	2,846,000	100.0%	2,669,000	100.0%

Premium revenue by segment, and as a percentage of consolidated totals, is as follows.

	For the Years Ended December 31,					
	2014		2013		2012	
Segment	Premium Revenue (In Millions)	Percentage of Total	Premium Revenue (In Millions)	Percentage of Total	Premium Revenue (In Millions)	Percentage of Total
Medicaid Health Plans	**$ 7,773.9**	**60.2%**	**$ 5,661.2**	**59.5%**	**$ 4,471.2**	**60.4%**
Medicare Health Plans	3,963.2	30.7%	3,071.0	32.3%	1,936.4	26.2%
Medicare PDPs	**1,178.4**	**9.1%**	**776.9**	**8.2%**	**992.6**	**13.4%**
Total	$ 12,915.5	100.0%	$ 9,509.1	100.0%	$ 7,400.2	100.0%

Medicaid Health Plans

Our Medicaid segment includes plans for beneficiaries of TANF, SSI, ABD, MLTC programs and other state-based programs that are not part of the Medicaid program, such as CHIP. For purposes of our Medicaid segment, we define our customer as the state and related governmental agencies that have common control over the contracts under which we operate in that particular state. As of January 1, 2015, we are the largest Medicaid health plan by membership in Florida, Georgia and Kentucky.

In February 2014, we executed a contract with the Florida Agency for Health Care Administration ("AHCA") to provide managed care services to Medicaid recipients in eight of the state's 11 regions as part of the state's Managed Medical Assistance ("MMA") program. These regions include the Jacksonville, Miami, Orlando, Tallahassee and Tampa metropolitan areas. The program commenced on May 1, 2014, with the implementation of three regions. Three additional regions were implemented in June, one in July and one in August. We served over 650,000 members in these regions as of December 31, 2014, compared to 394,000 members that we served in December 2013 under the prior Florida Medicaid program.

Additionally, effective January 1, 2014, we began offering Medicaid managed care in Essex, Hudson, Middlesex, Passaic and Union counties in New Jersey. In addition, effective July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst Health Plan of New Jersey, Inc. ("Healthfirst NJ"), which primarily relate to approximately 42,000 Healthfirst Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as certain provider agreements. As a result, effective July 1, 2014, we offer Medicaid managed care in 10 counties in New Jersey.

The Medicaid programs and services we offer to our members vary by state and county and are designed to effectively serve our constituencies in the communities in which we operate. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from primary care and preventive programs to full hospitalization and long-term care.

In general, members are required to use our network to receive care, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs. In addition, members generally must receive referrals from their primary care providers ("PCPs") in order to receive health care from a specialist, such as an orthopedic surgeon or neurologist. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

Medicaid Health Plans Membership

The following table summarizes our Medicaid Health Plans segment membership by the programs we offer.

	As of December 31,		
	2014	2013	2012
Medicaid Health Plans			
TANF	1,863,000	1,317,000	1,212,000
CHIP	178,000	212,000	207,000
SSI, ABD and duals	263,000	206,000	146,000
Other programs	6,000	24,000	22,000
Total	2,310,000	1,759,000	1,587,000

We received over 10% of our consolidated premium revenue in 2014, 2013 and 2012, individually, from the states of Florida, Georgia and Kentucky. The membership for those states is summarized in the following table.

	As of December 31,		
	2014	2013	2012
Medicaid Health Plans			
Florida	722,000	486,000	454,000
Georgia	604,000	540,000	570,000
Kentucky	420,000	292,000	207,000
All other states[1]	564,000	441,000	356,000
Total	2,310,000	1,759,000	1,587,000

(1) "All other states" consists of Hawaii, Illinois, and New York during all years presented. In 2012, it also includes Ohio; in 2013, it also includes Missouri and South Carolina; and in 2014, it also includes Missouri, New Jersey and South Carolina. Effective as of June 30, 2012, our Missouri contract expired and was not renewed. We re-entered Missouri Medicaid in March 2013 when we acquired Missouri Care. We were not awarded a Medicaid contract in Ohio for the 2013 fiscal year; however, the state of Ohio contracted with us to provide services to Ohio Medicaid beneficiaries through a transition period, which ended June 30, 2013.

Medicaid Health Plans Segment Revenues

Our Medicaid Health Plans segment generates revenues primarily from premiums received from the states in which we operate health plans. We receive a fixed premium per member per month ("PMPM") pursuant to our state contracts. Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. We generally receive premium payments during the month in which we provide services, although from time to time, we have experienced delays in receiving payments from certain states. In some instances, our base premiums are subject to risk score adjustments based on our members' acuity. Generally, the risk score is determined by the state by analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. In Georgia, Illinois, Kentucky, Missouri, New York and South Carolina we are eligible to receive supplemental payments for obstetric deliveries and newborns. We also received such supplemental payments in Ohio until June 30, 2013. Each contract is specific as to how and when these supplemental payments are earned and paid. Upon delivery of a newborn, the state agency is notified according to the contract terms. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for any subsequent updates to this data.

The following table sets forth information relating to premium revenues, net of premium taxes, from the states of Florida, Georgia and Kentucky, as well as all other states on an aggregate basis.

	For the Years Ended December 31,					
	2014		2013		2012	
State	Revenue (In Millions)	Percentage of Total Segment Revenue	Revenue (In Millions)	Percentage of Total Segment Revenue	Revenue (In Millions)	Percentage of Total Segment Revenue
Georgia	$ 1,624.3	20.9%	$ 1,513.5	26.7%	$ 1,460.8	32.7%
Florida	1,744.2	22.4%	1,109.3	19.6%	970.9	21.7%
Kentucky	2,287.3	29.4%	1,318.3	23.3%	723.7	16.2%
All other states[1]	2,041.6	26.3%	1,644.4	29.0%	1,233.6	27.6%
Premium taxes	76.5	1.0%	75.7	1.3%	$ 82.2	1.8%
Total	$ 7,773.9	100.0%	$ 5,661.2	100.0%	$ 4,471.2	100.0%

(1) "All other states" consists of Hawaii, Illinois, and New York during all years presented. In 2012, it also includes Ohio; in 2013, it also includes Missouri and South Carolina; and in 2014, it also includes Missouri, New Jersey and South Carolina. Effective as of June 30, 2012, our Missouri contract expired and was not renewed. We re-entered Missouri Medicaid in March 2013 when we acquired Missouri Care. We were not awarded a Medicaid contract in Ohio for the 2013 fiscal year; however, the state of Ohio contracted with us to provide services to Ohio Medicaid beneficiaries through a transition period, which ended June 30, 2013.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. We estimate the amounts due to the state agencies as a return of premium based on the terms of our contracts with the applicable state agency.

As discussed under Our Business-Medicare and Medicaid Health Programs, *Health Reform,* we have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014, as well as for 2015. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014.

Certain contracts expired in 2014, however, we are still serving members as if these contracts were still effective and expect the contracts to be renewed. Our other current Medicaid state contracts are set to expire or renew between June 2015 and June 2019. The following table sets forth the terms and expiration dates of our material Medicaid contracts with the states of Florida, Georgia and Kentucky, the three states that each accounted for greater than 10% of our consolidated premium revenues during 2014, 2013, and 2012.

State	Line of Business	Term of Contract	Expiration Date of Current Term
Florida	Medicaid (Staywell)	3-year term[1]	January 31, 2015
Florida	Medicaid (HealthEase)	3-year term[1]	January 31, 2015
Florida	Medicaid (MMA)	February 4, 2014 - December 31, 2018 [1]	December 31, 2018
Georgia	Medicaid and CHIP	1 potential one-year renewal [2]	June 30, 2015
Kentucky	Medicaid	3-year term with 4 potential one-year renewals [3]	June 30, 2015

(1) In 2014, AHCA awarded contracts for Medicaid managed care across the state. Our 2012-2015 Florida Medicaid contracts were terminated early in connection with the implementation of the new program. Our Staywell health plan participates in eight out of the state's 11 regions in the new program, which was fully implemented as of August 2014.

(2) Our Georgia contract commenced in July 2005. There is one remaining one-year option term, exercisable by the Georgia Department of Community Health ("Georgia DCH"), which would extend the total term until June 30, 2016. On February 9, 2015, the Georgia Department of Community Health issued a request for proposals for its Medicaid program, under which services would commence on July 1, 2016. We are currently preparing our response. A total of nine companies, including us, have been deemed qualified to bid.

(3) Our original Kentucky contract, not including Region 3, commenced in July 2011 and we began offering services to members on November 1, 2011. The contract has an initial three-year term and provides for four additional one-year option terms, exercisable upon mutual agreement of the parties, which potentially extends the total term until July 2018. The parties have exercised the first option term. In October 2012, we were awarded a contract by the Commonwealth of Kentucky to coordinate physical, behavioral and dental care for a total of approximately 170,000 Medicaid eligible beneficiaries in Medicaid Managed Care Region 3, which consists of 16 counties. We began serving Medicaid beneficiaries in Region 3 effective January 1, 2013.

Medicare Health Plans

Our Medicare Health Plans reportable segment includes the combined operations of both the MA and Medicare Supplement operating segments. We contract with CMS under the Medicare program to provide a comprehensive array of Part C and Part D benefits to Medicare eligible persons. These benefits are provided through our MA plans, which are comprised of CCPs. CCPs are administered through HMOs and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

As of December 31, 2014, we offered MA plans in a total of 402 counties across 18 states. In 2014, we served Medicare eligibles in 210 counties under the "WellCare" name, up from 204 counties in 2013. This included the addition of eight new counties in the states of Arizona, California and Kentucky, and the departure from one county in New Jersey and one county in Texas. As discussed above under "*Acquisitions*", we acquired Windsor in January 2014 and we served Medicare eligibles in 192 counties under the "Windsor" name in the states of Arkansas, Mississippi, South Carolina and Tennessee. Effective January 1, 2015 these plans were rebranded as WellCare MA plans.

In the 2015 plan year, we are offering MA plans in 376 counties in 15 states. We no longer offer MA plans in the states of Arizona, Missouri and Ohio, which represented 23 counties and approximately 8,000 members as of December 31, 2014. In addition, we departed from one county in Illinois and two counties in California in 2015.

We offer D-SNPs in 98% of the MA counties that we serve, and approximately 39% of our MA members are "dual-eligible" for Medicare and Medicaid and are enrolled in one of our D-SNPs. We cover a wide spectrum of medical services through our MA plans. For many of our plans, we provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, out-of-pocket expenses incurred by our members are generally reduced, which allows our members to better manage their health care costs. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

Some of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers, except in specific cases such as emergencies, transition of care or when specialty providers are unavailable in our network to meet their medical needs. MA CCP members may see out-of-network specialists if they receive referrals from their PCPs and may pay incremental cost-sharing.

In October 2014, our Medicare plans in Florida and California received 3.5 overall Star Ratings and our plans in Connecticut, Georgia, Hawaii, Illinois, New Jersey, New York and Texas achieved 3.0 overall Star Ratings, while our plans in Arizona, Louisiana and Missouri and our Windsor plans received at least one Star Rating of 2.5 for at least the third consecutive year. Our Medicare plans in Kentucky, New Jersey, and Ohio received at least one Star Rating of 2.5 for the first year.

On April 7, 2014, CMS revised their proposed 2015 rates, which we estimate will result in a rate decrease in the low single digit percentage compared with our 2014 rates.

In 2015, we will focus on three main areas in MA, including continuing execution on medical expense and quality initiatives led by our clinical services group, continuing to take a more disciplined portfolio approach to our MA bids for 2016, including a focus on net income, and continuing our efforts to improve on Star ratings, both in terms of execution on quality initiatives and our advocacy position to properly match the ratings, rules and economics with the prevalent data that demonstrates the causal connection between socio-economic status and lower quality ratings.

Medicare Health Plans Membership

As of December 31, 2014, 2013 and 2012, our Medicare Health Plans segment had approximately 417,000, 290,000 and 213,000 members, respectively. Membership at December 31, 2014 includes 37,000 and 43,000 MA and Medicare Supplement members, respectively, resulting from the Windsor acquisition, which closed on January 1, 2014.

Membership as of January 1, 2015, was 380,000, a 9% decrease from 417,000 as of December 31, 2014. The approximate decrease of 37,000 members was driven by actions taken in conjunction with our 2015 bid and county withdrawals in California designed to improve the performance of Easy Choice, which resulted in a 28,000 member decrease in California, as well as the Company's exit from the Missouri, Ohio, and Arizona markets representing 8,000 members as of December 31, 2014.

Medicare Health Plans Segment Revenues

The amount of premiums we receive for each MA member is established by contract, although the rates vary according to a combination of factors, including upper payment limits established by CMS, the member's geographic location, age, gender, medical history or condition, or the services rendered to the member. MA premiums are due monthly and are recognized as revenue during the period in which we are obligated to provide services to members. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly. The estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates have not had a material impact on premiums recorded during the periods presented.

Medicare Health Plans premium revenue for the year ended December 31, 2014, 2013 and 2012 was approximately $4.0 billion, $3.1 billion and $1.9 billion, respectively. We currently offer MA plans under separate contracts with CMS for each of the states in which we offer such plans, with the exception of the states in which we offer MA plans as a result of the Windsor acquisition. These states (Arkansas, Mississippi, South Carolina and Tennessee) are served under a single contract. Our MA contracts with CMS all have one year terms that expire at the end of each calendar year and are renewable for successive one-year terms unless CMS does not authorize a renewal or we notify CMS of our decision not to renew. Our current MA contracts expire on December 31, 2015.

Medicare Risk-Adjusted Premiums

CMS provides risk-adjusted payments for MA Plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which are possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year.

The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. Our Florida and Arizona MA plans have been selected by CMS for audits of the 2011 contract year and we anticipate that CMS will conduct audits of other contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could be significant, which would reduce our premium revenue in the year that CMS determines repayment is required.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDP plans to Medicare-eligible beneficiaries through our Medicare PDPs segment. We offer PDP plans in 49 states and the District of Columbia and are focused on value-conscious beneficiaries. Our PDP plans offer national in-network prescription drug coverage with approximately 71,000 pharmacies, including a preferred pharmacy network, subject to limitations in certain circumstances.

The PDP benefit design generally results in our incurring a greater portion of the responsibility for total prescription drug costs in the early stages of a plan year, and less in the latter stages of a plan year, due to the members' share of cumulative out-of-pocket costs increasing throughout the plan year. As a result, the PDP medical benefits ratio ("MBR") generally decreases throughout the year.

As discussed earlier in *Acquisitions*, in January 2014 we acquired Windsor, which offered PDP plans in 11 of the 34 CMS regions to approximately 103,000 beneficiaries as of December 31, 2014.

Our PDP contracts with CMS are renewable for successive one-year terms unless CMS notifies us of its decision not to renew by May 1 of the current contract year, or we notify CMS of our decision not to renew by the first Monday in June of the contract year.

Medicare PDPs Membership

As of December 31, 2014, 2013 and 2012, we served approximately 1,392,000, 797,000 and 869,000 PDP members, respectively. Membership as of December 31, 2014 increased by 595,000 compared to December 31, 2013, primarily as a result of our 2014 PDP bids, as well as the inclusion of membership from the Windsor acquisition. For 2014, our basic plan was below the benchmarks in 30 regions, of the 33 regions bid, and within the de minimis range in two other regions.

Due to changes in our bid design based on our 2014 experience, our 2015 PDP bids resulted in one of our basic plans being below the benchmarks in 13 of the 33 CMS regions for which we submitted bids, and within the de minimis range in nine other regions. We estimate that membership declined by approximately 21% to 1.1 million members as of January 1, 2015, as members who were auto assigned to us in 2014 and prior years in regions where our 2015 bids are not below the benchmark or within the de minimis range have been assigned to other plans. However, the outcome of our 2015 bids is expected to have a favorable impact on the 2015 segment results compared to 2014.

In 2015, we are retaining our auto-assigned members in the nine regions in which we bid within the de minimis range; however, we are not being auto-assigned new members in those regions. As of January 1, 2015, approximately 69% of our membership is comprised of beneficiaries that actively chose us for their current plan. We expect membership for the remainder of 2015 to be relatively stable, as we focus on marketing our PDP products to those who actively choose us to offset normal attrition.

Medicare PDPs Segment Revenues

Annually, we provide written bids to CMS for our PDPs, which reflect the estimated costs of providing prescription drug benefits over the plan year. Substantially all of the premium for this insurance is paid by the federal government, and the balance is due from the enrolled beneficiaries and, in some cases, state pharmacy assistance programs. The premium and subsidy components under Part D are described below.

Member Premium—We receive a monthly premium from members based on the plan year bid we submitted to CMS. The member premium, which is fixed for the entire plan year, is recognized over the contract period and reported as premium revenue.

CMS Direct Premium Subsidy—Represents monthly premiums from CMS based on the plan year bid submitted by us as a plan sponsor. The monthly payment is a risk-adjusted amount per member and is based upon the member's health status as determined by CMS. Refer to the "*Medicare Risk-Adjusted Premiums*" section under the "*Medicare Advantage (MA)*" segment discussion above for a more detailed description of risk-adjusted premiums.

Low-Income Premium Subsidy—For qualifying low-income subsidy ("LIS") members, CMS pays for some or all of the LIS member's monthly premium. The CMS payment is dependent upon the member's income level, which is determined by the Social Security Administration.

Low-Income Cost Sharing Subsidy ("LICS")—For qualifying LIS members, CMS reimburses us for all or a portion of the LIS member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold. LICS subsidies are paid by CMS prospectively as a fixed PMPM amount, as determined based upon the plan year bids submitted by us as a plan sponsor to CMS. Approximately nine to ten months subsequent to the end of the plan year, a settlement payment is made between CMS and our plans based on actual claims experience.

Catastrophic Reinsurance Subsidy—CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy. Catastrophic reinsurance subsidies are paid by CMS prospectively as a fixed PMPM amount, and are determined based upon the plan year bids submitted by us as a plan sponsor to CMS. Approximately nine to ten months subsequent to the end of the plan year, a settlement payment is made between CMS and our plans based on actual claims experience.

Coverage Gap Discount Subsidy—CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members. The prospective discount payments are determined based upon the plan year bid submitted by plan sponsors to CMS and current plan enrollment. Following the plan year, CMS performs an annual reconciliation of the prospective discount payments received by our plan to the amount of actual manufacturer discounts made available to each plan's enrollees under the program.

Catastrophic reinsurance subsidies and the low-income member cost sharing subsidies represent cost reimbursements under the Medicare Part D program. We are fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to us. Therefore, amounts received for these subsidies are not considered premium revenue, and are reported, net of the subsidy benefits paid, as Funds receivable/held for the benefit of members in the consolidated balance sheets. The receipts and payments between us and CMS are presented on a net basis as financing activity in our consolidated statements of cash flows since we are essentially administering and paying the benefit subsidies on behalf of CMS. Historically, the settlement payments between us and CMS have not been materially different from our recorded estimates. However, the balance of funds receivable from CMS grew substantially in 2014 due to increased drug costs relative to our bid estimates.

Coverage gap discount subsidies ("CGD") advance payments are recorded as funds receivable/held for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGD, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted claims data.

CMS Risk Corridor—Premiums from CMS are subject to risk sharing through the Medicare Part D risk corridor provisions. The CMS risk corridor calculation compares the target amount of prescription drug costs (limited to costs under the standard coverage as defined by CMS) less rebates in the plan year bid to actual experience. Variances of more than 5% above the target amount will result in CMS making additional payments to plan sponsors and variances of more than 5% below the target amount will require plan sponsors to refund to CMS a portion of the premiums received. Historically, we have not experienced material adjustments related to the CMS settlement of the prior plan year risk corridor estimate.

PDP premium revenue for the year ended December 31, 2014, 2013 and 2012 was approximately $1.2 billion, $776.9 million and $992.6 million, respectively.

OUR OPERATIONS

Provider Networks and Provider Reimbursement Methods

As of December 31, 2014, we contracted with approximately 224,000 health care providers and 71,000 pharmacies to provide our members with access to medically-necessary services. Our contracted providers deliver a variety of services to our members including: primary and specialty physician care; laboratory and imaging services; inpatient, outpatient, home health and skilled facility care; medication and injectable drug therapy; ancillary services; durable medical equipment and related services; mental health and chemical dependency counseling and treatment; transportation; and dental, hearing and vision care.

The following are the types of providers in our Medicaid and MA CCP contracted networks:

- *Professionals* such as PCPs, provider groups, specialty care physicians, psychologists and licensed social workers;
- *Facilities* such as hospitals with inpatient, outpatient and emergency services, skilled nursing facilities, outpatient surgical facilities and diagnostic imaging centers;
- *Ancillary providers* such as laboratory providers, radiology, home health, physical therapy, speech therapy, occupational therapy, ambulance providers and transportation providers; and
- *Pharmacies,* including retail pharmacies, mail order pharmacies and specialty pharmacies.

These providers are contracted through a variety of mechanisms, including agreements with individual providers, groups of providers, independent provider associations, integrated delivery systems and local and national provider chains such as hospitals, surgical centers and ancillary providers. We also contract with other companies who provide access to contracted providers, such as pharmacy, dental, hearing, vision, transportation and mental health benefit managers.

Facility, pharmacy, dental, vision and behavioral health contracts cover medically-necessary services and, under some of our plans, enhanced benefits. These contracts typically have terms of one to four years with some of the agreements automatically renewing at the end of the contract period, unless otherwise specified in writing by either party. During the contract period, these agreements typically can be terminated without cause upon written notice by either party, but the notification period may range from 90 to 180 days and early termination may subject the terminating party to financial penalties.

The contract terms require providers to participate in our quality improvement and utilization review programs, which we may modify from time to time. Providers must also adhere to applicable state and federal regulations.

We periodically review the fees paid to providers and make adjustments, as necessary. Generally, our contracts with providers do not allow for automatic annual increases in reimbursement levels. Among the factors generally considered in adjustments are changes to state Medicaid or Medicare fee schedules, competitive environment, current market conditions, anticipated utilization patterns and projected medical expenses. Some provider contracts are directly tied to state Medicaid or Medicare fee schedules, in which case reimbursement levels will be adjusted up or down, generally on a prospective basis, based on adjustments made by the state or CMS to the appropriate fee schedule.

Physicians and Provider Groups

PCPs play an important role in coordinating and managing the care of our Medicaid and MA CCP members. This coordination includes delivering preventive services as well as referring members to other providers for medically-necessary services. PCPs are typically trained in internal medicine, pediatrics, family practice, general practice or, in some markets, obstetrics and gynecology. In rare instances, a physician trained in sub-specialty care will perform primary care services for a member with a chronic condition.

PCPs and specialty care providers are typically reimbursed a specified fee for the service performed, which is known as fee-for-service. The specified fee is set as a percentage of the amount Medicaid or Medicare would pay under the applicable fee-for-service program.

We reimburse some of our PCPs and specialty care provider groups on a fixed-fee PMPM basis. This type of reimbursement methodology is commonly referred to as capitation. The reimbursement covers care provided directly by the provider as well as coordination of care from other providers as described above. In certain markets, we may also reimburse certain services such as vaccinations and laboratory or screening services delivered by the PCP in addition to the capitation payment.

For the years ended December 31, 2014 and 2013, approximately 6% of our payments to physicians serving our Medicaid members were on a capitated basis and approximately 94% were on a fee-for-service basis. During the years ended December 31, 2014 and 2013, approximately 17% of our payments to physicians serving our Medicare members in MA CCPs were on a capitated basis and approximately 83% were on a fee-for-service basis. Consistent with our long-term business priorities, we are putting increasing emphasis on aligning providers with our objective of improving healthcare quality by employing quality-based, performance-based, and shared risk contracting features in our provider agreements, as described below.

In some markets, PCPs may also be eligible for additional payments for achieving certain measurable levels of compliance with our clinical guidelines covering prevention and health maintenance or for managing patient utilization. The quality payments may be paid as a periodic bonus or when the PCP submits documentation of a member's receipt of services. For payments related to managing patient utilization, we establish a risk fund for each provider based on a percentage of premium received. We periodically evaluate and monitor this fund on an individual or group basis to determine whether these providers are eligible for additional payments or, in the alternative, whether they should reimburse us. Payments due to us are normally carried forward and offset against future potential surplus payments. PCPs participating in these specialized risk arrangements cover 68% and 25% of our MA and Medicaid membership, respectively, as of December 31, 2014. In 2015, we intend to increase our quality-based contracting with our PCPs.

In all instances, we require providers to submit data reporting all direct encounters with members. This data helps us to monitor the amount and level of medical treatment provided to our members to help improve the quality of care provided and comply with regulatory reporting requirements. Our regulators use the encounter data that we submit, as well as data submitted by other health plans, to set reimbursement rates, assign membership, assess the quality of care being provided to members and evaluate contractual and regulatory compliance.

To help ensure quality of care, we credential and re-credential all professional providers with whom we contract, including physicians, psychologists, licensed social workers, certified nurse midwives, advanced registered nurse practitioners and physician assistants who provide care under the supervision of a physician directly or through delegated arrangements. This credentialing and re-credentialing is performed in accordance with standards required by CMS and consistent with the standards of the NCQA.

Facilities

Our health plans arrange for hospital care primarily through contracts with selected hospitals in their service areas for coverage of medically-necessary care. These hospital contracts generally have multi-year terms or annual terms with automatic renewals and provide for payments on a variety of bases, including capitation, per diem rates, case rates and discounted fee-for-service schedules. These contracts typically can be canceled by either party, without cause, usually upon 90 days written notice.

In some cases, a longer notice period may be required, such as where a longer period is required by regulation or the applicable government contract.

Inpatient services are sometimes reimbursed as a fixed global payment for an admission based on the associated diagnosis related group, or DRG, as defined by CMS. In many instances, certain services, such as implantable devices or particularly expensive admissions, are reimbursed as a percentage of hospital charges either in addition to, or in lieu of, the DRG payment. Certain facilities in our networks are reimbursed on a negotiated rate paid for each day of the member's admission, known as a *per diem*. This payment varies based upon the intensity of services provided to the member during admission, such as intensive care, which is reimbursed at a higher rate than general medical services.

Facility outpatient services are reimbursed either as a percentage of charges or based on a fixed-fee schedule for the services rendered, in accordance with ambulatory payment groups or ambulatory payment categories, both as defined by CMS. Outpatient services for diagnostic imaging are reimbursed on a fixed-fee schedule as a percentage of the applicable Medicare or Medicaid fee-for-service schedule or a capitation payment.

Ancillary Providers

Our typical ancillary agreements provide for coverage of medically-necessary care and, in general, have terms of one year. These contracts automatically renew for successive one-year periods unless otherwise specified in writing by either party. These contracts typically can be canceled by either party, without cause, usually upon 90 days written notice. In some cases, a longer notice period may be required, such as where a longer period is required by regulation or the applicable government contract.

Ancillary providers, who provide services such as laboratory services, home health, physical, speech and occupational therapy, and ambulance and transportation services, are reimbursed on a capitation or fee-for-service basis.

Pharmacies

Pharmacy services are reimbursed based on a fixed fee for dispensing medication and a separate payment for the ingredients. Ingredients produced by multiple manufacturers are reimbursed based on a maximum allowable cost for the ingredient. Ingredients produced by a single manufacturer are reimbursed as a percentage of the average wholesale price. In certain instances, we contract directly with the sole-source manufacturer of an ingredient to receive a rebate, which may vary based upon volumes dispensed during the year.

Out-of-Network Providers

When our members receive services for which we are responsible from a provider outside our network, such as in the case of emergency room services from non-contracted hospitals, we generally attempt to negotiate a rate with that provider. In most cases, when a member is treated by a non-contracted provider, we are obligated to pay only the amount that the provider would have received from traditional Medicaid or Medicare.

Member Recruitment

Our member recruitment and marketing efforts for both Medicaid and Medicare members are heavily regulated by state agencies and CMS. For many products, we rely on the auto-assignment of members into our plans, including our PDP plan. The auto-assignment of a beneficiary into a health or prescription drug plan generally occurs when that beneficiary does not choose a plan. The agency with responsibility for the program determines the approach by which a beneficiary becomes a member of a plan serving the program. Some programs assign members to a plan automatically based on predetermined criteria. These criteria frequently include a plan's rates, the outcome of a bidding process, quality scores or similar factors. For example, CMS auto-assigns PDP members based on whether a plan's bids during the annual renewal process are above or below the CMS benchmark. In most states, our Medicaid health plans benefit from auto-assignment of individuals who do not choose a plan, but for whom participation in managed care programs is mandatory. Each state differs in its approach to auto-assignment, but one or more of the following criteria is typical in auto-assignment algorithms: a Medicaid beneficiary's previous enrollment with a health plan or experience with a particular provider contracted with a health plan, enrolling family members in the same plan, a plan's quality or performance status, a plan's network and enrollment size, awarding all auto-assignments to a plan with the lowest bid in a county or region, and equal assignment of individuals who do not choose a plan in a specified county or region.

Our Medicaid marketing efforts are regulated by the states in which we operate, each of which imposes different requirements for, or restrictions on, Medicaid sales and marketing. These requirements and restrictions can be revised from time to time. Several states, including our three largest Medicaid states, Florida, Georgia and Kentucky, do not permit direct sales by Medicaid health plans. We rely on member selection and auto-assignment of Medicaid members into our plans in those states.

Our Medicare marketing and sales activities are regulated by CMS and the states in which we operate. CMS has oversight over all, and in some cases has imposed advance approval requirements with respect to, marketing materials used by MA plans, and our sales activities are limited to activities such as conveying information regarding benefits, describing the operations of our managed care plans and providing information about eligibility requirements.

We also employ our own sales force and contract with independent, licensed insurance agents to market our MA and PDP products. We have continued to expand our use of independent agents whose cost is largely variable in nature and whose engagement is more conducive to the shortened Medicare selling season and the elimination of the open enrollment period. The activities of our independently-licensed insurance agents are also regulated by CMS. We also use direct mail, mass media and the Internet to market our products.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries, which is dependent on the outcome of a bid process whereby plans submit bids to CMS based on their estimated cost to provide services in designated regions. Plans that submit bids below the benchmark of other plans' bids in their bidding region are eligible for auto-assignment of LIS beneficiaries. For example, based on the outcome of our 2014 Medicare PDP bids, we were below the benchmarks in 30 of the 33 CMS regions for which we submitted bids. Due to changes in our bid design based on our 2014 experience, our 2015 PDP bids resulted in one of our basic plans being below the benchmarks in 13 of the 33 CMS regions for which we submitted bids. Therefore, our 2015 PDP membership has decreased to 1,098,000 as of January 1, 2015 compared to 1,392,000 as of December 31, 2014, as those PDP members who were previously auto-assigned to us have been reassigned to other plans in regions in which we were above the benchmark and the de minimis threshold. However, the outcome of our 2015 bids is expected to have a favorable impact on our 2015 PDPs financial performance compared to 2014. If our future PDP premium bids are not below the CMS benchmarks, we risk losing PDP members who were previously assigned to us and we may not have additional PDP members auto-assigned to us.

Quality Improvement

We are focused on improving quality across all of our lines of business, which is critical to the continued growth and success of our business. We continually seek to improve the quality of care delivered by our network providers to our members and our ability to measure the quality of care provided. Our quality improvement program provides the basis for our quality and utilization management functions and outlines ongoing processes designed to improve the delivery of quality health care services to our members, as well as to enhance compliance with regulatory and accreditation standards.

Our quality improvement activities will continue to focus on:

- Access;
- Preventive health and wellness and care management;
- Case and disease management;
- Health plan accreditation;
- Provider credentialing;
- Provider education and incentives for closing care gaps;
- Member education and outreach;
- Information technology initiatives related to the above activities;
- Advocacy and community-based programs; and
- Oversight and audits.

Access

We are focused on improving our members' access to a high-performing network of providers, including PCPs, specialists and ancillary providers, and ensuring that members see the appropriate providers, based on clinical condition. We help members access the right care at the right time in the appropriate setting through coordinated care teams and community partnerships. We recently added additional clinical resources in our markets to implement new care models.

Preventive health and wellness and care management

We sponsor a number of initiatives aimed at the promotion of healthy lifestyles and the prevention of disease, including preventive screenings, health education programs to inform members about health care issues and healthy behaviors and health assessment and counseling to inform members how to use the resources and services available to them to help reduce preventable diseases.

Case and disease management

We have enhanced our case management model to more effectively serve our most medically complex members. The model leverages both field-based and telephonic resources using state-specific, multi-disciplinary care teams. Our D-SNP case management helps reduce the fragmentation that exists in the current health care system, improving member access to quality care. We also employ intervention programs which include: a prenatal case management program to help women with high-risk pregnancies; a program to reduce the number of inappropriate emergency room visits; and disease management programs to decrease the need for emergency room visits and hospitalizations.

Health plan accreditation

Several of our health plans are accredited by nationally-recognized independent organizations that have been established to measure health plans' commitment to effective management and accountability. Our Florida, Georgia, Hawaii, Kentucky, Missouri and South Carolina HMOs are accredited by NCQA for Medicaid. Our Florida HMO is also NCQA accredited for Medicare.

Provider credentialing

We credential physicians, hospitals and other health care professionals in our participating provider networks using quality criteria, which meet or exceed the standards of external accreditation or state regulatory agencies, or both. Typically, most health care professionals are re-credentialed every three years, depending on applicable state laws.

Provider education and incentives for closing care gaps

As part of our quality improvement program, we have implemented changes to our reimbursement methods to reward certain providers who encourage preventive care, such as well-child check-ups, prenatal care and/or who adopt evidence based guidelines for members with chronic conditions. Additionally, several of our markets have provider incentives for closing care gaps inherent to the health care system. This initiative has resulted in increased member encounters to drive improvement in the quality of care.

Member education and outreach

We are focused on improving our members' access to a high-performing network of providers, including PCPs, specialists and ancillary providers, and ensuring that members see the appropriate providers, based on clinical condition. We have strengthened our resources focused exclusively on outreach to Medicaid and Medicare members to educate them on care gaps and to close those gaps. In addition, our medication therapy management initiatives empower patients to take an active role in managing their medications. Intervention and support activities include arranging transportation assistance, three-way calls with a member and his/her primary care physician to schedule appointments, and arranging for home visits to assess and close care gaps. We are focused on enhancing our members' experience by improving service and reducing complaint levels through improved grievance and appeals processes and member satisfaction surveys.

Information technology initiatives

We understand the importance of information technology in improving the level of service that we can provide to our members. Accordingly, we continue to invest in our information technology infrastructure and capabilities including tools that support our focus on improving our ability in providing members with quality health care. We have specialized systems to support our quality improvement activities and to gather information from our systems to identify opportunities to improve care and track the outcomes of the services provided to achieve those improvements, such as evaluating the effects of particular preventive measures.

Advocacy and community-based programs

WellCare connects community resources to help improve health outcomes and lower the overall cost of health care. WellCare works to link people to social services such as food banks or meal delivery, housing assistance, financial assistance, transportation, education support, legal assistance and employment services.

Oversight and audits

Internally, our quality improvement programs benefit from executive oversight and project management processes. Additionally, each of our health plans has a Quality Improvement Committee comprised of senior members of management, medical directors and other key associates of ours. Each of these committees report directly to the applicable health plan board of directors, which has ultimate oversight responsibility for the quality of care rendered to our members. The Quality Improvement Committees also have a number of subcommittees that are charged with monitoring certain aspects of care and service, such as health care utilization, pharmacy services and provider credentialing and re-credentialing. Several of these subcommittees include physicians as committee members.

Our board of directors recognizes the importance of delivering quality care and providing access to that care for our members and has established the Health Care Quality and Access Committee of the board. The primary purpose of this committee is to assist the board by reviewing, and providing general oversight of, our health care quality and access strategy, including our policies and procedures governing health care quality and access for our members. This input helps provide overall direction and guidance to our Quality Improvement Committees.

We conduct routine site audits of select providers and medical record audits to ensure the effectiveness of our quality improvement programs.

Information Technology

The accurate and timely capture, processing and analysis of critical data are cornerstones for providing managed care services. Focusing on data is also essential to operating our business in a cost effective manner. Data processing and data-driven decision making are key components of both administrative efficiency and medical cost management. We use our information system for premium billing, claims processing, utilization management, reporting, medical cost trending, planning and analysis. The system also supports member and provider service functions, including enrollment, member eligibility verification, primary care and specialist physician roster access, claims status inquiries, and referrals and authorizations.

On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. This evaluation may result in enhancing or replacing current systems and/or processes, which could result in our incurring substantial costs to improve our operations and services. We continue to work to improve service and productivity, and to comply with future regulatory requirements such as the implementation of ICD-10 by October 2015.

We have a disaster recovery plan that addresses how we recover business functionality within stated timelines. We have an agreement with a nationally-recognized, third-party vendor to provide for the restoration of our general support systems at a remote processing center. We perform disaster recovery testing at least annually for those business applications that we consider critical. Additionally, we recently formed an Information Technology Oversight Committee of the Board of Directors in order to assist the Board in its oversight of the Company's major information technology (IT) initiatives, to consult with senior management with respect to the Company's IT strategy, assist the Board in its oversight of the Company's IT security programs and assist the Audit and Finance Committee of the Board in its oversight of the Company's IT internal controls and its disaster recovery capabilities and strategies.

Reinsurance

We bear underwriting and reserving risks associated with our HMO and insurance subsidiaries. In 2014 and prior years, we retained certain of these risks through our wholly-owned, captive insurance subsidiary. Effective January 1, 2015, we are no longer ceding new risks to our captive insurance subsidiary. We reduce exposure to large catastrophic losses by insuring levels of coverage for losses in excess of what we retain internally with highly-rated, unaffiliated insurance companies. However, we remain liable in the event these insurance companies are unable to pay their portion of the losses, so we regularly monitor the financial condition of these companies to ensure that they are maintaining these high ratings.

Outsourcing Arrangements

Our care and service delivery model is designed to optimize our use of our personnel versus third parties based on an evaluation of factors, including cost, compliance, quality and procurement success. As a result, we have contracted with a number of vendors to provide significant operational support including, but not limited to, pharmacy benefit management for our members as well as certain enrollment, billing, call center, benefit administration, claims processing, mail order pharmacy, sales and marketing and certain aspects of utilization management. For example, in November 2014, we outsourced our mail order pharmacy. We also intend to change pharmacy benefit managers in 2016, which may create operational challenges and transition and transitory costs as a new vendor is implemented. Where a vendor provides services that we are required to

provide under a contract with a government customer, we are responsible for such performance and will be held accountable by our government customers for any failure of performance by our vendors. We evaluate the competency and solvency of our third-party vendors prior to execution of contracts and include service level guarantees in our contracts, where appropriate. Additionally, we perform ongoing vendor oversight activities to identify any performance or other issues related to our vendors.

Centralized Management Services

We provide centralized management services to each of our health plans from our Tampa, Florida headquarters and call centers. These services include information technology, product development and administration, finance, human resources, accounting, legal, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, customer service and certain aspects of clinical service and are provided by an affiliated administrator.

Employees

We refer to our employees as associates. As of December 31, 2014, we had approximately 6,700 full-time associates. Our associates are not represented by any collective bargaining agreement, and we have never experienced a work stoppage.

OUR COMPETITION

Competitive Environment

We operate in a highly competitive environment to manage the cost and quality of services that are delivered to government health care program beneficiaries. We currently compete in this environment by offering Medicare and Medicaid health plans in which we accept all or nearly all of the financial risk for management of beneficiary care under these programs.

We typically must be awarded a contract by the government agency with responsibility for a program in order to offer our services in a particular location. Some government programs choose to limit the number of plans that may offer services to beneficiaries, while other agencies allow an unlimited number of plans to serve a program, subject to each plan meeting certain contract requirements. When the number of plans participating in a program is limited, an agency generally employs a bidding process to select the participating plans.

As a result, the number of companies with which we compete varies significantly depending on the geographic market, business segment and line of business. We believe a number of our competitors have strengths that may match or exceed our own with respect to one or more of the criteria on which we compete with them. Further, some of our competitors may be better positioned than us to withstand rate compression.

Competitive Factors—Program Participation

Regardless of whether the number of health plans serving a program is limited, we believe government agencies determine program participation based on several criteria. These criteria generally include the terms of the bids as well as the breadth and depth of a plan's provider network; quality and utilization management processes; responsiveness to member complaints and grievances; timeliness and accuracy of claims payment; financial resources; historical contractual and regulatory compliance; quality scores, references and accreditation; and other factors. As discussed in *Member Recruitment,* a significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries, which is dependent on the outcome of a bid process whereby plans submit bids to CMS based on their estimated cost to provide services in designated regions.

Competitive Factors—Network Providers

In addition, we compete with other health plans to contract with hospitals, physicians, pharmacies and other providers for inclusion in our networks that serve government program beneficiaries. We believe providers select plans in which they participate based on several criteria. These criteria generally include reimbursement rates; timeliness and accuracy of claims payment; potential to deliver new patient volume and/or retain existing patients; effectiveness of resolution of calls and complaints; and other factors.

Obtaining Members

The agency with responsibility for a particular program determines the approach by which a beneficiary becomes a member of one of the plans serving the program. Generally, government programs either assign members to a plan automatically or they permit participating plans to market to potential members, though some programs employ both approaches. For more information about auto-assignment and how we obtain our members generally, see the *Member Recruitment* discussion above.

Medicaid Competitors

In the Medicaid managed care market, our principal competitors for state contracts, members and providers include the following types of organizations:

- *MCOs*—Managed care organizations ("MCOs") that, like us, receive state funding to provide Medicaid benefits to members. Many of these competitors operate in a single or small number of geographic locations. There are a few multi-state Medicaid-only organizations that are able to leverage their infrastructure over a larger membership base. Competitors include private and public companies, which can be either for-profit or non-profit organizations, with varying degrees of focus on serving Medicaid populations.

- *Medicaid Fee-For-Service*—Traditional Medicaid offered directly by the states or a modified version whereby the state administers a primary care case management model.

- *PSNs*—A Provider Service Network ("PSN") is a network of providers that is established and operated by a health care provider or group of affiliated health care providers. A PSN operates as either a fee-for-service ("FFS") health plan or as a prepaid health plan that, like us, receives a capitated premium to provide Medicaid benefits to members. A PSN that operates as a FFS health plan is not at risk for medical benefit costs. FFS PSNs are at risk for 50% of their administrative cost allocation if their total costs exceed the estimated at-risk capitation amount.

Medicare Competitors

In the Medicare market, which includes Medicare Advantage, Medicare Supplemental Insurance, and Prescription Drug Plans; our primary competitors for contracts, members and providers include the following types of competitors:

- *Original Fee-For-Service Medicare*—Original Medicare is available nationally and is a fee-for-service plan managed by the federal government. Beneficiaries enrolled in Original Medicare can go to any doctor, supplier, hospital or other facility that accepts Medicare and is accepting new Medicare patients.

- *Medicare Advantage and Prescription Drug Plans*—MA and stand-alone Part D plans are offered by national, regional and local MCOs and insurance companies that serve Medicare beneficiaries. In addition, prescription drug plans are being offered by or co-branded with retail drug store chains or other retail store chains, which may be able to offer lower priced plans and achieve benefits from integration with their pharmacy benefit management operations.

- *Employer-Sponsored Coverage*—Employers and unions may subsidize Medicare benefits for their retirees in their commercial group. The group sponsor solicits proposals from MA plans and may select an HMO, PPO and/or PDP to provide these benefits.

- *Medicare Supplements*—Original Medicare pays for many, but not all, health care services and supplies. A Medicare supplement policy, commonly called "Medigap", is private health insurance designed to supplement Original Medicare by covering the cost of items such as co-payments, coinsurance and deductibles. Some Medicare supplements cover additional benefits for an additional cost. Medicare supplement plans can be used to cover costs not otherwise covered by Original Medicare, but cannot be used to supplement MA plans.

REGULATION IMPACTING OUR BUSINESS

Our health care operations are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services is an ever-evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws, statutes, regulations and interpretive guidance occur frequently. These changes may include a requirement to provide health care services not contemplated in our current contracted premium rate or to pay providers at a state-mandated fee schedule without a commensurate adjustment to the premium rate. For further information, see the *Our Operations- Provider Networks and Provider Reimbursement Methods* discussion above. In addition, government agencies may impose taxes, fees or other assessments upon us and other managed care companies at any time.

Our contracts with various state government agencies and CMS to provide managed health care services include provisions regarding provider network adequacy, maintenance of quality measures, accurate submission of encounter and health care cost information, maintaining standards of call center performance, prompt payment of claims and other requirements specific to government and program regulations. We must also have adequate financial resources to protect the state, our providers and our members against the risk of our insolvency. Our failure to comply with these requirements may result in the assessment of

penalties, fines and liquidated damages. For further information on data provided to CMS that is subject to audit, refer to the *Product Segments-Medicare Health Plans- Medicare Risk-Adjusted Premiums* discussion above.

Government enforcement authorities have become increasingly active in recent years in their review and scrutiny of various sectors of the health care industry, including health insurers and managed care organizations. We routinely respond to subpoenas and requests for information from these entities and, more generally, we endeavor to cooperate fully with all government agencies that regulate our business.

Product Compliance

Medicaid programs

Medicaid is state operated and implemented, although it is funded by both the state and federal governments. Within guidelines established by the federal government, each state:

- establishes its own eligibility standards;
- determines the type, amount, duration and scope of services;
- sets the rate of payment for services; and
- administers its own program.

We have entered into contracts with Medicaid agencies in each state in which we operate Medicaid plans. Some of the states in which we operate award contracts to applicants that can demonstrate that they meet the state's minimum requirements. Other states engage in a competitive bidding process for all or certain programs. In either case, we must demonstrate to the satisfaction of the respective agency that we are able to meet certain operational and financial requirements. For example:

- we must measure provider access and availability in terms of the time needed for a member to reach the doctor's office;
- our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- we must have linkages with schools, city or county health departments and other community-based providers of health care in order to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- we must have the capability to meet the needs of disabled members;
- our providers and member service representatives must be able to communicate with members who do not speak English or who are hearing impaired; and
- our member handbook, newsletters and other communications must be written at the prescribed reading level and must be available in certain languages other than English.

Once awarded, our Medicaid program contracts generally have terms of one to three years. Most of these contracts provide for renewal upon mutual agreement of the parties, or at the option of the government agency, and both parties have certain early termination rights. In addition to the operating requirements listed above, state contract requirements and regulatory provisions applicable to us generally set forth detailed provisions relating to subcontractors, marketing, safeguarding of member information, fraud and abuse reporting and grievance procedures.

Our Medicaid plans are subject to periodic financial and informational reporting and comprehensive quality assurance evaluations. We regularly submit periodic utilization reports, operations reports and other information to the appropriate Medicaid program regulatory agencies.

Our compliance with the provisions of our contracts is subject to monitoring or examination by state regulators and their agents. Certain contracts require us to be subject to quality assurance evaluations and accreditation by a third-party organization.

Medicare programs

Medicare is a federal health insurance program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance and prescription drug benefits. Medicare beneficiaries have the option to enroll in various types of MA plans, such as MA CCP plans, PPO benefit plans or MA private-fee-for-service plans, in areas where such plans are offered. Under MA, managed care plans contract with CMS to provide benefits that are comparable to, or that may be more attractive to Medicare beneficiaries than, Original Medicare in exchange for a fixed monthly payment per member that varies based on the county in which a member resides, the demographics of the member and the member's health condition. Currently, we only offer CCP plans under the MA program.

All Part D plans, both PDPs and Medicare Advantage-Prescription Drug Plans ("MA-PDs"), bid on providing Part D benefits in June of each year. Based on the bids submitted, CMS establishes a benchmark for each of the 33 regions. CMS pays the Part D plans a percentage of the benchmark on a PMPM basis with the remaining portion of the premium being paid by the Medicare member. Members whose income falls below 150% of the federal poverty level qualify for the federal LIS, through which the federal government helps pay the member's Part D premium and certain other cost sharing expenses.

Each of our MA and PDP plan contracts with CMS are on a calendar-year basis. CMS requires that each plan meet certain regulatory requirements including, as applicable: provisions related to enrollment and disenrollment; restrictions on marketing activities; benefits or formulary requirements; quality assessment; encounter data reports; fraud, waste and abuse monitoring; maintaining relationships with health care providers; and responding to appeals and grievances.

Our MA and PDP plans perform ongoing monitoring of our compliance with the CMS requirements, including functions performed by vendors. From time to time, CMS conducts examinations of our compliance with the provisions of our MA and PDP contracts.

Licensing and Solvency Regulation

Our operations are conducted primarily through HMO and insurance subsidiaries. These subsidiaries are licensed by the insurance departments in the states in which they operate, except our New York HMO subsidiary, which is licensed as a prepaid health services plan by the New York State Department of Health, and our California HMO, which is licensed by the California Department of Managed Health Care. The subsidiaries are subject to the rules, regulations and oversight of the applicable state agencies in the areas of licensing and solvency. State insurance laws and regulations prescribe accounting practices for determining statutory net income and capital and surplus. Each of our regulated subsidiaries is required to report regularly on its operational and financial performance to the appropriate regulatory agency in the state in which it is licensed. These reports describe each of our regulated subsidiaries' capital structure, ownership, financial condition, certain intercompany transactions and business operations. From time to time, any of our regulated subsidiaries may be selected to undergo periodic audits, examinations or reviews by the applicable state agency of our operational and financial assertions.

Our regulated subsidiaries generally must obtain approval from, or provide notice to, the state in which it is domiciled before entering into certain transactions such as declaring dividends in excess of certain thresholds, entering into other arrangements with related parties, acquisitions or similar transactions involving an HMO or insurance company, or any change in control. For purposes of these laws, in general, control commonly is presumed to exist when a person, group of persons or entity, directly or indirectly, owns, controls or holds the power to vote 10% or more of the voting securities of another entity.

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, risk-based capital ("RBC") requirements or other financial ratios. The RBC requirements are based on guidelines established by the NAIC, and have been adopted by most states. The statutory framework for our regulated subsidiaries' minimum capital requirements could change over time. For instance, RBC requirements may be adopted by more of the states in which we operate. In addition, regulators could require our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators determine that maintaining such additional statutory net worth is in the best interest of our members and other constituencies. Failure to maintain these requirements would trigger regulatory action by the state. Such statues, regulations and capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our HMO and insurance subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries that may not be transferable to us in the form of loans, advances, or cash dividends was approximately $746.0 million at December 31, 2014, and $489.0 million at December 31, 2013. The combined statutory capital and surplus of our HMO and insurance subsidiaries was $1.3 billion and $1.1 billion at December 31, 2014 and 2013, respectively, which was in compliance with the minimum capital requirements as of those dates.

Our regulated subsidiaries are also subject to restrictions on their ability to make dividend payments. Dividend restrictions vary by state, but the maximum amount of dividends which can be paid without prior approval from the applicable state is subject to restrictions relating to statutory capital, surplus and net income for the previous year. Some states require prior approval of all dividends, regardless of amount. States may disapprove any dividend that, together with other dividends paid by a subsidiary in the prior 12 months, exceeds the regulatory maximum as computed for the subsidiary based on its statutory surplus and net income. We received $68.0 million, $147.0 million and $192.0 million in dividends from our regulated subsidiaries during the years ended December 31, 2014, 2013, and 2012, respectively. The 2014 amount included $36 million not requiring prior regulatory approval, and $32 million paid after obtaining prior regulatory approval. Under applicable regulatory requirements at December 31, 2014, the amount of dividends that may be paid through the end of 2015 by our HMO

and insurance subsidiaries without prior approval by regulatory authorities is approximately $60.0 million in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

HIPAA and State Privacy Laws

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations adopted under HIPAA are intended to improve the portability and continuity of health insurance coverage and simplify the administration of health insurance claims and related transactions. All health plans, including ours, are subject to HIPAA. HIPAA generally requires health plans, as well as their providers and vendors, to:

- protect the privacy and security of patient health information through the implementation of appropriate administrative, technical and physical safeguards; and
- establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format.

We are also subject to state laws that provide for greater privacy of individuals' health information; such laws are not preempted by HIPAA.

Fraud and Abuse Laws

Federal and state enforcement authorities have prioritized the investigation and prosecution of health care fraud, waste and abuse. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing and violation of patient privacy rights. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we have structured our compliance program with care in an effort to meet all statutory and regulatory requirements, our policies and procedures are continuously under review and subject to updates and our training and education programs are always evolving. We have invested significant resources to enhance our compliance efforts and we expect to continue to do so.

Federal and state laws and regulations governing submission of information and claims to agencies

We are subject to federal and state laws and regulations that apply to the submission of information and claims to various agencies. For example, the federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a "whistleblower" such as a disgruntled former associate, competitor or member) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit.

A number of states, including states in which we operate, have adopted false claims acts that are similar to the federal False Claims Act.

PRINCIPAL EXECUTIVE OFFICES

Our principal executive offices are located at 8725 Henderson Road, Renaissance One, Tampa, Florida 33634, and our telephone number is (813) 290-6200.

AVAILABILITY OF REPORTS AND OTHER INFORMATION

Our corporate website is *http://www.wellcare.com*. We make available on this website or in print, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, Proxy Statement and amendments to those materials filed or furnished pursuant to Section 13(a) or 15(d) of the Securities and Exchange Act of 1934, as amended, as soon as reasonably practicable after we electronically file such materials with, or furnish such materials to, the Securities and Exchange Commission ("SEC").

Also available on our website, or in print to any stockholder upon request, are WellCare's Corporate Governance Guidelines and Code of Conduct and Business Ethics, as well as charters of the following committees of the board of directors: the Audit and Finance Committee, Compensation Committee, Health Care Quality and Access Committee, Information Technology Oversight Committee, Nominating and Corporate Governance Committee and Regulatory Compliance Committee. In addition, we intend to disclose any amendments to, or waivers of, our Code of Conduct and Business Ethics on our website. To obtain printed materials contact Investor Relations at WellCare Health Plans, Inc., 8725 Henderson Road, Tampa, Florida 33634. In addition, the SEC's website is *http://www.sec.gov.* The SEC makes available on its website, free of charge, reports, proxy and information statements, and other information regarding issuers, such as us, that file electronically with the SEC. Information provided on our website or on the SEC's website is not part of this Annual Report on Form 10-K.

Item 1A. Risk Factors

You should carefully consider the following factors, together with all of the other information included in this report, in evaluating our company and our business. If any of the following risks actually occur, our business, financial condition and results of operations could be materially and adversely affected, and the value of our stock could decline. The risks and uncertainties described below are those that we currently believe may materially affect our company. Additional risks and uncertainties not presently known to us or that we currently deem immaterial also may impair our business operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties.

Risks Related to Our Business

If we are unable to estimate and manage medical benefits expense effectively, our profitability likely will be reduced or we could become unprofitable.

Our profitability depends, to a significant degree, on our ability to estimate and effectively manage our costs related to the provision of health care services. Relatively small changes in the ratio of our expenses related to health care services to the premiums we receive (the "medical benefits ratio" or "MBR") can create significant changes in our financial results. Many aspects of the managed care business are not predictable, and estimating medical benefits expense is a continuous process, which depends on the information available to us and our ability to utilize such information. Factors that may cause medical benefits expense to exceed our estimates include:

- the addition of new members, whether by acquisition, new enrollment, program startup or expansion (including geographic expansion), whose risk profiles are uncertain or unknown and for whom initiatives to manage their care take longer than expected;
- an increase in the cost of health care services and supplies, including pharmaceuticals, whether as a result of the introduction of new products or technologies, inflation or otherwise;
- the performance of our pharmaceutical benefit manager in managing our pharmaceutical costs;
- higher-than-expected utilization of health care services;
- contractual provisions related to continuity of care for new members;
- periodic renegotiation of hospital, physician and/or other provider contracts;
- the occurrence of catastrophes, major epidemics, terrorism or bio-terrorism;
- changes in the demographics of our members and medical trends affecting them;
- challenges in implementing medical expense cost control initiatives, especially during the first year of a new Medicaid program; and
- new mandated benefits, increased mandated provider reimbursement rates or other changes in health care laws, regulations and/or practices.

The factors and assumptions that are used to develop our estimates of costs, including medical benefits expense, inherently are subject to greater variability when there is more limited experience or information available to us, such as when we commence operations in a new state or region or commence participation in a new program. In many cases, the degree of our ability to accurately estimate medical benefits expense may not be known until we have sufficient experience and more complete information. For example, levels of plan utilization and members' use of medical services, provider claims submissions, our payment processes and other factors can result in identifiable patterns emerging only following the passage of a significant period of time after the occurrence of the underlying causes of deviations from our assumptions. If our medical benefits expense increases and we are unable to manage these medical costs effectively in the future, our profits would likely be reduced or we may not remain profitable, which would also affect our liquidity, cash flows and our ability to comply with statutory requirements.

Most of our revenues are generated by premiums consisting of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries, depending on the type of member in our plans. These payments are fixed by contract and we are obligated during the contract period, which is generally one to five years, to provide or arrange for the provision of health care services as established by states and the federal government. The payments are generally set based on an estimation of the medical costs using actuarial methods based on historical data. Actual experience, however, could differ from the assumptions used in the premium-setting process, which could result in premiums being insufficient to cover our medical benefits expense. For example, several new, extremely high cost hepatitis C drugs were approved in 2014. In addition, in the new Florida MMA program, our claims experience has been running significantly higher than we originally estimated. Because the new Florida MMA program has required its participating plans to utilize the state's drug formulary, it is more difficult for us to manage the pharmaceutical costs. In addition, we experienced unfavorable development of prior year reserve amounts in three of the four quarters in 2013, and in the first and second quarters of 2014, particularly in our Medicaid and Medicare Health Plans segments. Our medical benefits expense may exceed our estimates or our regulators' actuarial pricing

assumptions and we may be unable to adjust the premiums we receive under our current contracts, which could have a material adverse effect on our results of operations.

Our MA and PDP plans, as well as certain of our Medicaid plans, are subject to a minimum medical loss ratio ("MLR"), which requires health plans to spend not less than a certain percentage of premiums on medical benefits. If a minimum MLR is not met, then we could be required to refund premiums back to the state or CMS, as applicable.

In addition, there are sometimes wide variations in the established rates per member in both our Medicaid and Medicare lines of business. For instance, the rates we receive for a Supplemental Security Income ("SSI") member are generally significantly higher than for a non-SSI member who is otherwise similarly situated. As the composition of our membership base changes as the result of programmatic, competitive, regulatory, benefit design, economic or other changes; there is a corresponding change to our premium revenue, costs and margins, which may have a material adverse effect on our cash flow and results of operations.

Some provider contracts are directly tied to state Medicaid or Medicare fee schedules, which the state or CMS, respectively, may increase without granting a corresponding increase in premiums to us. We have experienced similar types of adjustments in other states in which we operate. Unless such adjustments are mitigated by an increase in premiums, or if this were to occur in any more of the states in which we operate, our profitability will be negatively impacted.

Also, in some rural areas, it is difficult to maintain a provider network sufficient to meet regulatory requirements. In situations where we have a deficiency in our provider network, regulators require us to allow members to obtain care from out-of-network providers at no additional cost, which could have a material adverse effect on our ability to manage expenses. In some states, with respect to certain services, the amount that the health plan must pay to out-of-network providers for services provided to our members is defined by law or regulation, but in certain instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. Out-of-network providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with the health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustments of the payment could adversely affect our financial position, results of operations or cash flows.

Although we maintain reinsurance to protect us against certain severe or catastrophic medical claims, we cannot assure that such reinsurance coverage currently is or will be adequate or available to us in the future or that the cost of such reinsurance will not limit our ability to obtain it.

Our pharmacy benefit manager may not perform at the level of our expectations, resulting in additional pharmacy costs or administrative costs, which would affect the profitability of our Medicaid Health Plans segment, our Medicare PDP segment and our MA plans that contain a prescription drug benefit, and could adversely affect our results of operations and cash flows.

Our pharmacy benefit manager may not perform at the level of our expectations, resulting in additional pharmacy costs or administrative costs, which would reduce the profitability of our Medicaid Health Plans segment, our Medicare PDP segment and the MA plans that also contain a prescription drug benefit. Further, because our 2015 MA and PDP bids do not account for such additional costs, and we would not be reimbursed for additional pharmacy costs that are the responsibility of CMS until the fourth quarter of 2016, our results of operations and cash flows could be adversely affected, perhaps materially.

We rely on a number of third parties, and failure of any one of the third parties to perform in accordance with our contracts could have a material adverse effect on our business and results of operations.

Our care and service delivery model is designed to optimize our use of our personnel as an alternative to third parties based on an evaluation of factors, including cost, compliance, quality and procurement success. As a result, we have contracted with a number of third parties to provide significant operational support including, but not limited to, pharmacy benefit management for our members as well as certain enrollment, billing, call center, benefit administration, claims processing functions, sales and marketing and certain aspects of utilization management. We have limited ability to control the performance of these third parties. If a third party provides services that we are required to provide under a contract with a government client, we are responsible for such performance and will be held accountable by the government client for any failure of performance by our vendors. Significant failure by a third party to perform in accordance with the terms of our contracts could subject us to fines or other sanctions or otherwise have a material adverse effect on our business and results of operations. In addition, upon termination of a third party contract, we may encounter difficulties in replacing the third party on favorable terms, transitioning services to another vendor, or in assuming those responsibilities ourselves, which may have a material adverse effect on our business, quality scores and results of operations. For example, we intend to change pharmacy benefit managers in 2016, which may create operational challenges and transition and transitory costs as a new vendor is implemented. In addition, in November 2014, we outsourced our mail order pharmacy. Further, we rely on state-operated

systems and sub-contractors to qualify and assign eligible members into our health plan. Ineffectiveness of these state operations and sub-contractors can have a material adverse effect on our enrollment.

Failure to maintain satisfactory quality scores could negatively impact our premium rates, subject us to penalties, limit or reduce our membership, impede our ability to compete for new business in existing or new markets or result in the termination of our contracts, which would have a material adverse effect on our business, rate of growth and results of operations.

Quality scores are used by certain agencies to establish premium rates or, in the case of the Centers for Medicare & Medicaid Services ("CMS"), to pay bonuses to Medicare Advantage ("MA") plans that enable high scoring plans to offer enhanced member health benefits which are attractive to members.

Certain provisions in the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA") tie MA premiums to the achievement of Star Ratings. Beginning in 2015, only MA plans that have a 4.0 or higher overall quality score, or "Star Rating", (out of five) will be eligible for a quality bonus in their basic premium rates. Plans that receive quality bonuses may have a competitive advantage in the Medicare market, as they may be able to offer more attractive benefit packages to members and/or achieve higher profit margins. None of our plans achieved a 4.0 Star Rating in 2014, so we will not receive these quality bonuses in 2015, and we may not be able to improve our Star Ratings, to receive these quality bonuses in the future.

In addition, plans with any Star Ratings below 3.0 for three consecutive years risk contract termination. In 2014, our MA plans in Louisiana and the MA plans of Windsor Health Group, Inc. ("Windsor") we acquired in January 2014, representing approximately 47,000 members as of January 1, 2015, each received at least one Star Rating of 2.5 for at least the third consecutive year. If these Star Ratings do not equal or exceed 3.0 by the 2015 Star Rating release date, these plans may be terminated by CMS as early as plan year 2016. We serve a larger percentage of D-SNP members than our competitors, and this population is more challenging to serve. CMS's quality measurement methodology does not account for population differences between plans, and therefore, we may be unable to achieve a four star rating for some of our plans. Furthermore, plans deemed low performing that participate in state Medicare-Medicaid dual-eligible demonstration programs are ineligible for passive enrollment, which is likely to result in lower market share in those programs.

In certain state Medicaid programs, plans that do not meet applicable quality measures can be required to refund premiums previously received, may not be able to earn quality bonuses, may be required to pay penalties, or may be subject to enrollment limitations, including suspension of auto assignment of members, or termination of the contract. In addition, if the state determines that a health plan has failed to meet the contractual requirements for quality measures, these contracts may be subject to termination, or other remedies, such as liquidated damages, at the discretion of the state. We are unable to predict what actions a state may take, if any, when assessing our contractual performance.

In addition, lower quality scores compared to our competitors may adversely impact our ability to attract members and obtain regulatory approval for acquisitions or expansions. As a result, lower quality scores compared to our competitors could have a material adverse effect on our business, rate of growth and results of operations.

Difficulties in successfully estimating and managing growth may have a material adverse effect on our quality scores, results of operations, financial position and cash flows.

Our membership has grown substantially in the last three years due to acquisitions, geographic expansions and organic growth. This rapid growth has strained our operations, medical management and information technology resources. We may not be successful in improving our infrastructure to support this growth, and delays in infrastructure improvements may have a material adverse effect on our quality scores, results of operations, financial position and cash flows. In addition, due to the substantial initial costs related to acquisitions and expansions, such growth could adversely impact our short-term profitability and liquidity.

As part of our growth strategy, we identify potential acquisition targets, bid and negotiate acquisition terms, work with regulators to receive regulatory approval for the acquisition and once the transaction is closed, we must integrate the acquisition into our operations. In 2012, we completed two acquisitions, Easy Choice Health Plan, Inc. in California and certain assets of Desert Canyon Community Care in Arizona, and in the first quarter of 2013, we completed our acquisition of UnitedHealth Group Incorporated's South Carolina Medicaid plan and Aetna, Inc.'s Missouri Medicaid plan. In January 2014, we completed our acquisition of Windsor from Munich Health North America, Inc., a part of Munich Re. Through its subsidiaries, Windsor serves Medicare beneficiaries with Medicare Advantage, Prescription Drug Plan and Medicare Supplement products. We are still integrating certain aspects of these acquisitions into our operations.

On June 30, 2014, we acquired certain Medicaid-related assets of Healthfirst Health Plan of New Jersey, Inc. ("Healthfirst NJ"), with the transfer of membership effective as of July 1, 2014. The acquired assets primarily relate to approximately 42,000 Healthfirst NJ Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as certain provider agreements. As a result, beginning July 1, 2014, we offer Medicaid managed care in 10 counties in New Jersey.

Once an attractive acquisition target is identified, we may not be successful in bidding against competitors. Other potential acquirers may have greater financial resources or different profitability criteria than we have. Depending on the transaction size, we may not be able to obtain appropriate financing, especially in light of the volatility in the capital markets over the past several years.

Even if we are successful in bidding against competitors, we may not be able to obtain the regulatory approval from federal and state agencies required to complete the acquisition. We may not be able to comply with the regulatory requirements necessary for approval of the acquisition or state regulators may give preference to competing offers made by locally-owned entities, competitors with higher quality scores or not-for-profit entities.

Once acquired, we may have difficulties integrating the businesses within our existing operations, due to factors such as:

- new associates who must become familiar with our operations and corporate culture;
- acquired provider networks that operate on different terms than our existing networks and whose contracts may need to be renegotiated;
- existing members who decide to switch to another health care plan;
- disparate administrative and information technology systems; and
- difficulties implementing our operations strategy to operate the acquired businesses profitably.

As a result, our acquired businesses may not perform as we anticipated, or in line with our existing businesses. In addition, if the expected future profitability of the acquired business declines, we may need to write down or incur impairment charges of the acquired assets. For example, during the year ended December 31, 2014, we recorded a charge of $18.0 million to reflect the impairment of certain intangible assets associated with the acquisition of Easy Choice in 2012, and fully impaired the assets we acquired from Desert Canyon Community Care in Arizona, due to our decision to exit the Arizona MA market. In the future, we may incur additional material expenses in connection with the integration and execution of acquisitions, expansions, and other significant transactions.

Furthermore, we may incur significant transaction expenses in connection with a potential acquisition or expansion opportunity, which may not be successful. These expenses could impact our selling, general and administrative expense ratio. If we are unable to effectively execute our acquisition strategy or integrate acquired businesses, our future growth may suffer and our profitability may decrease.

Our rate of expansion into other geographic areas may also be inhibited by factors such as:

- the time and costs associated with obtaining the necessary licenses and approvals to operate;
- lower quality scores compared to our competitors;
- participation in fewer lines of business compared to our competitors;
- our inability to develop a network of physicians, hospitals and other health care providers that meets our requirements and those of government regulators;
- CMS or state contract provisions regarding quality measures, such as CMS Star Ratings;
- competition, which increases the cost of recruiting members;
- the cost of providing health care services in those areas;
- demographics and population density; and
- applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus.

In any program start-up, acquisition, expansion, or re-bid, the implementation of the contract as designed may be affected by factors beyond our control. These include political considerations, network development, contract appeals, incumbency, participation in other lines of business, membership assignment (allocation of members who do not self-select), errors in the bidding process, changes to the program design or implementation timing, difficulties experienced by other private vendors involved in the implementation, such as enrollment brokers, and noncompliance with contractual requirements with which we do not yet have experience and similar risks. As a result, our business, particularly plans for expansion or increased membership levels, could be negatively impacted.

In addition, when making award determinations and evaluating proposed acquisitions and expansions, regulators frequently consider the plan's historical regulatory compliance, litigation and reputation and we are required to disclose

material investigations and litigation, including in some cases investigations and litigation that occurred in the past. As a result of the previous federal and state investigations, stockholder and derivative litigation, the restatement during 2009 of our previously issued financial statements and related matters, and the criminal trial of certain of our former executives and employees that concluded in the second quarter of 2013, we have been, and may continue to be, the subject of negative publicity. As a result, continuing negative publicity and other negative perceptions regarding these matters may adversely affect our ability to grow.

Our Medicaid operations are concentrated in a limited number of states. Loss of a material contract, reduced premium rates, or delayed payment of earned premiums may adversely impact our business, financial condition or results of operations.

Our concentration of Medicaid operations in a limited number of states could cause our revenue, profitability or cash flow to change suddenly and unexpectedly as a result of significant premium rate reductions, payment delays, loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, epidemics, pandemics, unexpected increases in utilization, advances in medical technology and pharmaceutical therapies, difficulties in managing provider costs, general economic conditions and similar factors in those states. Our inability to continue to operate in any of these states, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, or results of operations. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in these states could therefore have a disproportionately adverse effect on our operating results.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicare Advantage, Medicaid, and Children's Health Insurance Program ("CHIP"). We provide those health care services under contracts with regulatory entities in the areas in which we operate. For the year ended December 31, 2014, our Medicaid operations in Florida, Georgia and Kentucky each accounted for greater than 10% of our consolidated premium revenue, net of premium taxes. These customers accounted for contracts that have terms of between one and three years with varying expiration dates.

Our Medicaid contracts are generally intended to run for one to five years and in some cases may be extended for additional years if the state or other sponsoring agency elects to do so. When our state contracts expire, they may be opened for bidding by competing health care plans. For example, the last renewal option under our Georgia Medicaid contract expires in June 2016. On February 9, 2015, the Georgia Department of Community Health issued a request for proposals for its Medicaid program, under which services would commence on July 1, 2016. We are currently preparing our response. A total of nine companies, including us, have been deemed qualified to bid. The request for proposals indicates up to four companies may be selected to participate. In addition, the State of Missouri has issued a request for proposals for its Medicaid program for the period between July 1, 2015 and June 30, 2016, with two possible annual renewal periods. We have responded and are currently waiting for the state's contract award decision. There is no guarantee that our contracts will be renewed or extended or, if renewed or extended, on what terms. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed or extended, renewed or extended on less favorable terms, or not renewed or extended on a timely basis, or if an increased number of competitors were awarded contracts in these states, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

State governments generally are experiencing tight budgetary conditions within their Medicaid programs. As a result, government agencies with which we contract may seek funding alternatives, which may result in reductions in funding for their Medicaid programs. If any state in which we operate were to decrease premiums paid to us for these reasons or any other reason, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our revenues and results of operations. We have experienced such rate decreases in the past and may do so in the future. Economic conditions affecting state governments and agencies could also result in delays in receiving premium payments. If there is a significant delay in our receipt of premiums to pay health benefit costs, it could have a material adverse effect on our results of operations, cash flows and liquidity.

A significant percentage of our Medicaid plan enrollment results from mandatory enrollment in Medicaid managed care plans. States may mandate that certain types of Medicaid beneficiaries enroll in Medicaid managed care through CMS-approved state plan amendments or, for certain groups, through federal waivers or demonstrations. Waivers and programs under demonstrations are generally approved for two- to five-year periods, and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate does not mandate managed care enrollment in its state plan or does not renew an existing managed care waiver, our membership would likely decrease, which could have a material adverse effect on our results of operations.

We derive a significant portion of our revenue from our PDP operations, for which we submit annual bids for participation. The results of our bids could materially reduce our cash flow, liquidity, revenue and profits.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2014 Medicare PDP bids were below the benchmarks in 30 of the 33 CMS regions for which we submitted bids. However, our 2015 PDP bids resulted in one of our basic plans being below the benchmarks in 13 of the 33 CMS regions for which we submitted bids and within the de minimis range in nine other regions. This resulted from the realignment of our benefit designs and cost structure. We may not be able to submit bids which are below benchmarks of other plans' bids in future years. Our membership has decreased in 2015 compared to 2014 as those PDP members who had been auto assigned to us in regions where our 2015 bids are not below or within the de minimis range have been assigned to other plans. For those regions in which we are within the de minimis range, we will not be eligible to have new members auto-assigned to us, but we will not lose our existing auto-assigned membership. If our future Part D premium bids are not below the CMS benchmarks, we risk losing PDP members who were previously assigned to us and we may not have additional PDP members auto-assigned to us, which could materially reduce our revenue and profits.

In 2014, our segment PDP MBR was higher than our expectation primarily due to higher utilization of branded and specialty drugs by our new members. We may not be successful in improving our segment MBR in the future, which would materially reduce our profits. For additional risks associated with estimating and managing our MBR, see "*If we are unable to estimate and manage medical benefits expense effectively, our profitability likely will be reduced or we could become unprofitable*" above.

Because the estimated costs of providing prescription drugs in our 2014 bids were substantially lower than our actual costs of providing prescription drugs, our funds receivable from CMS is higher than we anticipated. As a result, our unregulated cash and the net proceeds from a $300.0 million term loan drawn in September 2014 are being used to fund the costs of providing prescription drugs until the funds receivable from CMS are actually paid to us, which we expect to occur in the fourth quarter of 2015. Until such time, our cash flow and liquidity will be adversely affected, perhaps materially.

We may not be able to generate or access sufficient cash to service all of our indebtedness, and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

As of December 31, 2014, we had approximately $900.0 million in aggregate principal amount of total indebtedness outstanding consisting of a $300.0 million term loan and $600.0 million senior notes due 2020 (the "notes"). In addition, our credit agreement provides us with up to an additional $300.0 million of borrowing ability thereunder. Our ability to make scheduled payments on or to refinance our debt obligations depends on our and our subsidiaries' financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, competitive, legislative, regulatory and other factors beyond our control. As a result, we may not be able to maintain a level of cash flows from operating activities, or to access the cash flows of our subsidiaries in an amount sufficient to permit us to pay the principal and interest on our indebtedness, including the notes and the credit agreement. We cannot assure that our business will generate sufficient cash flow from operations, or that financing sources will be available to us in amounts sufficient to enable us to pay our indebtedness, including the notes and the credit agreement, or to fund our other liquidity needs.

In September 2014, we amended and restated our existing credit agreement to provide for a $300.0 million term loan, which expires in September 2016, to fund our PDP operations due to a receivable from CMS that has been accumulating during 2014. The PDP receivable from CMS primarily relates to low-income subsidies and catastrophic reinsurance coverage (reinsurance) provided by CMS under the Medicare PDP program. Because our 2014 PDP bids for the estimated costs of providing prescription drugs were substantially lower than our actual costs of providing prescription drugs, our funds receivable from CMS is higher than we anticipated. As a result, our unregulated cash and the proceeds from the term loan facility are being used to fund costs of providing prescription drugs until the funds receivable from CMS are actually paid to us, which we expect will occur in the fourth quarter of 2015. In addition, if our costs of providing prescription drugs in 2015 are higher than our estimates included in our 2015 PDP bids, then we could accumulate an additional large receivable from CMS. Our cash flow and liquidity could be adversely affected, perhaps materially.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure or refinance our indebtedness, including the notes. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments

and the indenture that governs the notes may restrict us from adopting some or all of these alternatives. If we are unable to pay our indebtedness on time, it could result in the acceleration of our indebtedness and materially adversely affect us.

If we commit a material breach of our Corporate Integrity Agreement, we may be excluded from certain programs, resulting in the revocation or termination of contracts and/or licenses potentially having a material adverse effect on our results of operations.

On April 26, 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of the Inspector General of the Department of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to us under review by OIG-HHS. The Corporate Integrity Agreement requires us to maintain various ethics and compliance programs that are designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, who we call associates, requirements for reporting to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, our reporting practices and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement, we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS will exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and potentially have a material adverse effect on our business and results of operations.

The requirements of the ACA, may have a material adverse effect on our results of operations, financial position and cash flows.

We believe the ACA will continue to bring about significant changes to the American health care system. These measures are intended to expand the number of United States residents covered by health insurance and make other coverage, delivery, and payment changes to the current health care system. The costs of implementing the ACA will be financed, in part, from substantial additional fees and taxes on us and other health insurers, health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the individual mandate contained in the ACA and modified the Medicaid expansion provisions to make the expansion optional for states. Some states have decided not to participate in the Medicaid expansion, and more states may choose not to participate in the future. Congress may also withhold the funding necessary to fully implement the ACA, may attempt to replace the legislation with amended provisions or could seek to repeal the law altogether. In 2015, the U. S. Supreme Court is scheduled to consider whether premium subsidies can be used in a federally facilitated exchange. Given the breadth of possible changes and the uncertainties of interpretation, implementation, and timing of these changes, which we expect to occur over the next several years, the ACA could change the way we do business, potentially impacting our pricing, benefit design, product mix, geographic mix, and distribution channels.

Regulations and policies related to the implementation of the ACA, the Budget Control Act of 2011, and the Continuing Appropriations Act of 2014, as well as future legislative changes, may have a material adverse effect on our results of operations, financial position, and cash flows by:

- restricting revenue, enrollment and premium growth in certain products and market segments;
- restricting our ability to expand into new markets;
- increasing our medical and administrative costs;
- lowering our Medicare payment rates and/or increasing our expenses associated with the non-deductible federal premium tax and other assessments;
- encouraging states to contract with organizations that are not subject to the annual premium-based health insurance industry assessment imposed by the ACA (the "ACA industry fee") for their Medicaid programs; and
- encouraging states to integrate Medicare and Medicaid using a limited number of health plans or a fee for service model.

In addition, the response of other companies to these policy, regulatory and legislative changes and adjustments to their offerings, if any, could have a meaningful impact in the health care markets.

The ACA includes a number of changes that could impact the way MA plans will operate, such as:

- ***Reduced Medicare Premium Rates.*** On April 7, 2014, CMS revised their proposed 2015 rates, which we estimate will result in a rate decrease in the low single digit percentage from our 2014 rates.

- ***CMS Star Ratings.*** Certain provisions in the ACA tie MA premiums to the achievement of Star Ratings. Beginning in 2015, MA plans with an overall Star Rating of four or more stars will be eligible for a quality bonus in their basic premium rates. Plans that receive quality bonuses may have a competitive advantage in the Medicare market, as they may be able to offer more attractive benefit packages to members and/or achieve higher profit margins. Also, beginning with open enrollment for the 2014 plan year, Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years have been excluded from mention in the CMS "Medicare and You" handbook, denoted as "low performing" plans on the CMS website, and excluded from on-line enrollment through the Medicare Plan Finder website. These actions may adversely impact these plans' ability to maintain or increase membership. CMS could exercise its authority and terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2015. However, CMS could still exercise its authority and terminate those plans for the plan year 2016. We serve a larger percentage of D-SNP members than our competitors, and this population is more challenging to serve. CMS's quality measurement methodology does not account for population differences between plans, and therefore, we may be unable to achieve a four star rating for some or all of our plans. Our MA plans in Louisiana and our Windsor MA plans, representing approximately 47,000 members as of January 1, 2015, could be terminated effective December 31, 2015 if their Part C and Part D star ratings are not at least three stars for the plan year 2016. While we are continuing efforts to improve our Star Ratings and other quality measures, there is no guarantee that we will be able to maintain or improve our Star Ratings.

- ***Minimum MLRs.*** Beginning in 2014, the ACA requires the establishment of a MLR for MA plans and Part D plans, requiring them to spend not less than 85% of premiums on medical benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. MLR is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees).

Under the ACA, over a 10-year period beginning in 2010, the "coverage gap" (i.e., the dollar threshold at which an individual has to pay full price for his or her medications) under Part D has been gradually closing, with beneficiaries retaining a 25% co-pay in 2020. While this change will ultimately result in increased insurance coverage for beneficiaries, such improved benefits could result in changes in member behavior with respect to drug utilization. Such actions could impact the cost structure of our PDPs.

The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers which began in 2014. The total ACA industry fee levied on the health insurance industry was $8 billion in 2014 and will be $11.3 billion in 2015, with increasing annual amounts thereafter, and growing to $14.3 billion by 2018. After 2018, the industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S. health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. We incurred $137.7 million of such fees in 2014 and currently estimate that we will incur between $230 and $235 million in such fees in 2015, due to the increase in the total fee to be levied on the industry and the expected increase in our share of total 2014 industry premiums. However, the 2015 final fee amount will not be determined until August 2015. We have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014. We have also obtained similar commitments from our Medicaid customers for 2015. CMS does not directly reimburse us for the impact of the ACA industry fee related to MA and PDP premiums.

The health reforms in the ACA allow, but do not require, states to expand eligibility for Medicaid programs. As a result, the effects of any potential future expansions and future federal financing are uncertain, making it difficult to determine whether the net impact of the ACA will be positive or negative for our Medicaid business.

Future changes in health care law present challenges for our business that could have a material adverse effect on our results of operations and cash flows.

Future changes in, or interpretations to, existing health care laws or regulations, or the enactment of new laws or the issuance of new regulations could materially reduce our revenue and/or profitability by, among other things:

- imposing additional license, registration and/or capital requirements;
- increasing our administrative and other costs;
- requiring us to change our operating structure;
- requiring significant additional reporting and technological capabilities;
- imposing additional fees and taxes, which cannot be offset by increased premium revenue;
- increasing mandated benefits;
- further limiting our ability to engage in intra-company transactions with our affiliates and subsidiaries;
- restricting our revenue and enrollment growth;
- requiring us to restructure our relationships with providers; and
- requiring us to implement additional or different programs and systems.

Requirements relating to increased plan information disclosure, expedited appeals and grievance procedures, third party review of certain medical decisions, health plan liability, access to specialists, "clean claim" (a claim for which no additional information is needed), payment methodologies and timing, utilization of mail order pharmacy, administrative simplification, mandatory network inclusion of certain providers, mandated increases in provider reimbursement rates, physician collective bargaining rights, centralized credentialing and confidentiality of medical records either have been enacted or are under consideration. Changes in state law, regulations and rules also may have a material adverse impact on our results of operations and cash flows.

The ACA ends funding for CHIP as of September 30, 2015 and the Special Needs Program has only been authorized through December 31, 2016. If these programs are not funded, renewed or extended, it could have a material adverse impact on our revenues, cash flow, membership and profitability.

Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, cash flows and ability to bid for, and continue to participate in, certain programs.

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been and could be exposed to operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We have experienced challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the premium rates we receive and how membership is assigned to us, which could have a material adverse effect on our results of operations, cash flows and our ability to bid for, and continue to participate in, certain programs.

We encounter significant competition for program participation, members, network providers, key personnel and sales personnel and our failure to compete successfully may limit our ability to increase or maintain membership in the markets we serve, or have a material adverse effect on our business, growth prospects and results of operations.

We operate in a highly competitive industry. Some of our competitors are more established in the insurance and health care industries, with larger market share, greater financial resources and better quality scores than we have in some markets. We operate in, and may attempt to acquire business in, programs or markets in which premiums are determined on the basis of a competitive bidding process. In these programs or markets, funding levels established by bidders with significantly different cost structures, target profitability margins or aggressive bidding strategies could negatively impact our ability to maintain or acquire profitable businesses, which could have a material adverse effect on our results of operations.

We did not to participate in the health insurance exchange products during 2014 and we are only participating in the exchanges in Kentucky and New York in 2015. As a result, individuals who select an exchange product in our other states, and subsequently become eligible for a Medicaid plan that we offer, may be less likely to select or be assigned to us.

Regulatory reform or other initiatives may bring additional competitors into our markets. Regulators may prefer companies that operate in lines of business in which we do not operate when we bid on new business or renewals of existing business, which may cause our bid or renewal to be unsuccessful.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We may not be able to develop innovative products and services that are attractive to members. We cannot be sure that we will continue to remain competitive, nor can we be sure that we will be able to successfully retain or acquire members for our products and services at current levels of profitability.

In addition, we compete with other health plans to contract with hospitals, physicians, pharmacies and other providers for inclusion in our networks that serve government program beneficiaries. We believe providers select plans in which they participate based on several criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints and other factors. We cannot be sure that we will be able to successfully attract or retain providers under acceptable contract terms to maintain a competitive network in the geographic areas we serve.

We may not be able to attract or retain qualified management, clinical and commercial personnel in the future due to the intense competition for qualified personnel in the managed care and health care industry. If we are not able to attract and retain necessary personnel to accomplish our business objectives, we may experience constraints that will significantly impede the achievement of our objectives, our ability to raise additional capital and our ability to implement our business strategy. In particular, if we lose any members of our senior management team, we may not be able to find suitable replacements, and our business may be harmed as a result. In addition, we have in the past and may in the future modify our senior management structure, which could impact our retention of employees and management.

Our MA plans are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may also recommend and/or market health care benefits products of our competitors, and we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract or retain sales personnel and third-party brokers, consultants and agents or if we do not adequately provide support, training and education to this sales network regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, maintain or increase our revenue growth, and control medical cost trends and/or our pricing flexibility, may be adversely affected. Failure to compete successfully in the markets we serve may have a material adverse effect on our business, growth prospects and results of operations.

Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in material retroactive adjustments that have a material adverse effect on our results of operations, financial position and cash flows.

Most of our government customers employ risk-adjustment models to determine the premium amount they pay for each member. This model pays more for members with predictably higher costs according to the health status of each beneficiary enrolled. Premium payments are generally established at fixed intervals according to the contract terms, and then adjusted on a retroactive basis. We reassess the estimates of the risk adjustment settlements each reporting period and any resulting adjustments are made to premium revenue. In addition, revisions to the risk-adjustment models have reduced, and may continue to reduce, our premium revenue.

As a result of the variability of certain factors that determine estimates for risk-adjusted premiums, including plan risk scores, the actual amount of retroactive payments could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. The data provided to our government customers to determine the risk score are subject to audit by them even after the annual settlements occur. These audits may result in the refund of premiums to the government customer previously received by us, which could be significant and would reduce our premium revenue in the year that repayment is required.

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. Our Florida and Arizona MA plans have been selected by CMS for audits of the 2011 contract year and we anticipate that CMS will conduct audits of other contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. It is likely that a

payment adjustment could occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows.

Recent changes in our senior management may cause uncertainty in, or be disruptive to, our business, results of operations, financial condition and the market price of our common stock.

We have recently experienced significant changes in our senior management. Effective January 1, 2015, Kenneth Burdick, previously our President and Chief Operating Officer, was promoted to Chief Executive Officer, replacing David Gallitano, our interim Chief Executive Officer. In December 2014, Blair Todt, previously our Senior Vice President, Chief Strategy and Development Officer, assumed the newly created role of Senior Vice President, Chief Legal and Administrative Officer and Secretary replacing Lisa Iglesias and her role as Senior Vice President, General Counsel and Secretary. In November 2014, Andrew Asher replaced Thomas Tran as our Chief Financial Officer. In April 2014, Michael Yount, our former Chief Privacy Officer, replaced Cyndi Baily as our Senior Vice President and Chief Compliance Officer. In February 2014, Rose Hauser joined us as our Chief Information Officer. These changes in our senior management may be disruptive to our business and, during the transition period, there may be uncertainty among investors, employees and others concerning our future direction and performance. Any such disruption or uncertainty could have a material adverse impact on our results of operations and financial condition and the market price of our common stock.

We are subject to extensive government regulation and risk of litigation, and any actual or alleged violation by us of the terms of our contracts, applicable laws or regulations could have a material adverse effect on our results of operations.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders and creditors. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with our members, providers and the public. Any actual or alleged violation by us of applicable laws or regulations could reduce our revenues and profitability, thereby having a material adverse effect on our results of operations.

We face a significant risk of class action lawsuits and other litigation and regulatory investigations and actions in the ordinary course of operating our businesses. The following are examples of types of potential litigation and regulatory investigations we face:

- claims by government agencies relating to compliance with laws and regulations;
- claims relating to sales practices;
- claims relating to the methodologies for calculating premiums;
- claims relating to the denial or delay of health care benefit payments;
- claims relating to claims payments and procedures;
- claims relating to provider marketing;
- claims by providers for network termination or exclusion;
- anti-kickback claims;
- medical malpractice or negligence actions based on our medical necessity decisions or brought against us on the theory that we are liable for our providers' malpractice or negligence;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts or defamation claims;
- allegations of discrimination;
- allegations of breaches of duties;
- claims relating to inadequate or incorrect disclosure or accounting in our public filings and other statements;
- allegations of agent misconduct;
- claims related to deceptive trade practices; and
- claims relating to audits and contract performance.

As we contract with various governmental agencies to provide managed health care services, we are subject to various reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit, investigation or result from litigation could result in:

- loss of our right to participate in government-sponsored programs, including Medicaid and Medicare;
- forfeiture or recoupment of amounts we have been paid pursuant to our government contracts;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key associates;
- reduction or limitation of our membership;
- damage to our reputation in various markets;

- increased difficulty in marketing our products and services;
- inability to obtain approval for future acquisitions or service or geographic expansion;
- suspension or loss of one or more of our licenses to act as an insurer, HMO or third party administrator or to otherwise provide a service; and
- an event of default under our debt agreements.

In particular, because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties and assessments. Many states, including states where we currently operate, have enacted parallel legislation. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent.

Some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Liability for such matters could have a material adverse effect on our financial position, results of operations and cash flows. Qui tam actions under federal and state law can be brought by any individual on behalf of the government. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to defend false claim actions, pay fines or be excluded from Medicare, Medicaid or other state or federal health care programs as a result of investigations arising out of such actions.

For example, in October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of its civil inquiry, it was investigating four qui tam complaints filed by relators against us under the whistleblower provisions of the False Claims Act. We also learned from a docket search that a former employee filed a qui tam action in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries. With respect to these actions, we reached a settlement with the Civil Division, the Civil Division of the United States Attorney's Office for the Middle District of Florida, and the Civil Division of the United States Attorney's Office for the District of Connecticut. However, other qui tam actions may have been filed against us of which we are presently unaware, or other qui tam actions may be filed against us in the future.

We are currently undergoing standard periodic audits by several state agencies and CMS to verify compliance with our contracts and applicable laws and regulations. For additional risks associated with these audits, see "*Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in material retroactive adjustments that have a material adverse effect on our results of operations, financial position and cash flows*" above.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We rely on the accuracy of eligibility lists provided by our government clients to collect premiums, and any inaccuracies in those lists may cause states to recoup premium payments from us, which could materially reduce our revenues and results of operations.

Premium payments that we receive are based upon eligibility lists produced by our government clients. A state will require us to reimburse it for premiums that we received from the state based on an eligibility list that it later discovers contains individuals who were not eligible for any government-sponsored program, have been enrolled twice in the same program, have secondary insurance or are eligible for a different premium category, or a different program. Our review of remittance files may not identify all member eligibility errors and could result in repayment of premiums in years subsequent to the year in which the revenue was recorded. We have established a reserve in anticipation of recoupment by the states of previously paid premiums that we believe to be erroneous, but ultimately our reserve may not be sufficient to cover the amount, if any, of recoupments. If the amount of any recoupment exceeds our reserves, our revenues could be materially reduced and it could have a material adverse effect on our results of operations.

In addition to recoupment of premiums previously paid, we also face the risk that a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be reduced as a result of the state's failure to pay us for related payments we made to providers and were unable to recoup.

If we are unable to access sufficient capital, whether as a result of difficulties finding acceptable public or private financing, restrictions under our credit agreement, the notes, restrictions on dividend payments from our subsidiaries, or higher levels of required statutory capital, we may be unable to grow or maintain our business, which could have a material adverse effect on our results of operations, cash flows and financial condition.

Our business strategy has been defined by four long-term business priorities, one of which includes our ability to enter new markets by pursuing attractive growth opportunities for our existing product lines. We may need to access the debt or equity markets and receive dividends from our subsidiaries to fund these growth activities.

Our ability to enter new markets may be hindered in situations where financing may not be available on terms that are favorable to us, or at all. Financing may only be available to us with unfavorable terms such as high rates of interest, restrictive covenants and other restrictions that could impede our ability to profitably operate our business and increase the expected rate of return we require to enter new markets, making such efforts unfeasible.

Our credit agreement and notes have restrictions on our ability to secure additional capital. Our substantial indebtedness and restrictive covenants:

- limit our ability to borrow additional funds for working capital, capital expenditures, acquisitions and general corporate or other purposes; and
- expose us to greater interest rate risk since the interest rate on borrowings under our credit agreement is variable.

Our debt service obligations require us to use a portion of our operating cash flow to pay interest and principal on indebtedness instead of for other corporate purposes, including funding future expansion of our business and ongoing capital expenditures, which could impede our growth. If our operating cash flow and capital resources are insufficient to comply with the financial covenants in the credit agreement or to service our debt obligations, we may be forced to sell assets, seek additional equity or debt financing or restructure our debt, which could harm our long-term business prospects.

Our credit agreement and notes also contain various restrictions and covenants that restrict our financial and operating flexibility, including our ability to grow our business or declare dividends without lender approval. If we fail to pay any of our indebtedness when due, or if we breach any of the other covenants in the instruments governing our indebtedness, one or more events of default may be triggered. If we are unable to obtain a waiver, these events of default could permit our creditors to declare all amounts owed to be immediately due and payable.

In addition, in most states, we are required to seek the prior approval of state regulatory authorities to transfer money or pay dividends from our regulated subsidiaries in excess of specified amounts or, in some states, any amount. If our state regulators do not approve payments of dividends and/or distributions by certain of our regulated subsidiaries to us or our non-regulated subsidiaries, our liquidity, unregulated cash flows, business and financial condition may be materially adversely affected.

Our licensed HMO and insurance subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital and maintenance of certain financial ratios, as defined by each state. One or more of these states may raise the statutory capital level from time to time, which could have a material adverse effect on our cash flows and liquidity.

Our subsidiaries also may be required to maintain higher levels of statutory capital due to the adoption of risk-based capital requirements by other states in which we operate. Our subsidiaries are subject to their state regulators' general oversight powers. Regardless of whether a state adopts the risk-based capital requirements, the state's regulators can require our subsidiaries to maintain minimum levels of statutory net worth in excess of amounts required under the applicable state laws if they determine that maintaining such additional statutory net worth is in the best interests of our members and other constituents. For example, if premium rates are inadequate, reduced profits or losses in our regulated subsidiaries may cause regulators to increase the amount of capital required. Any additional capital contribution made to one or more of the affected subsidiaries could have a material adverse effect on our liquidity, cash flows and growth potential. In addition, increases of statutory capital requirements could cause us to withdraw from certain programs or markets where it becomes economically difficult to continue operating profitably.

Our indemnification obligations and the limitations of our director and officer liability insurance may have a material adverse effect on our financial condition, results of operations and cash flows.

Under Delaware law, our charter and bylaws and certain indemnification agreements to which we are a party, we have an obligation to indemnify, or we have otherwise agreed to indemnify, certain of our current and former directors, officers and associates with respect to current and future investigations and litigation. In connection with some pending matters, including

the recent criminal trial of certain of our former executives and associates, we are required to, or we have otherwise agreed to, advance, and have advanced, significant legal fees and related expenses and expect to continue to do so while these matters are pending. We have exhausted our insurance for the expenses associated with the criminal trial of our former executive officers and associates, and the related government investigations that commenced in 2007, and further expenses incurred by us for these matters will not be reimbursed.

We currently maintain insurance in the amount of $125.0 million which provides coverage for our independent directors and officers hired after January 24, 2008 for certain potential matters to the extent they occur after October 2007. We cannot provide any assurances that pending claims, or claims yet to arise, will not exceed the limits of our insurance policies, that such claims are covered by the terms of our insurance policies or that our insurance carrier will be able to cover our claims.

We are exposed to fluctuations in the securities and debt markets, which could impact our investment portfolio.

Our investment portfolio represents a significant portion of our assets and is subject to general credit, liquidity, market and interest rate risks. Market fluctuations in the securities and credit markets could impact the value or liquidity, of our investment portfolio and adversely impact interest income. As a result, we may experience a reduction in value or loss of liquidity which may materially impact our results of operations, liquidity and financial condition.

Risks Related to Ownership of Our Stock

We are subject to laws, government regulations and agreements that may delay, deter or prevent a change in control of our Company, which could have a material adverse effect on our ability to enter into transactions favorable to stockholders.

Our operating subsidiaries are subject to state laws that require prior regulatory approval for any change of control of an HMO or insurance company. For purposes of these laws, in most states "control" is presumed to exist when a person, group of persons or entity acquires the power to vote 10% or more of the voting securities of another entity, subject to certain exceptions. These laws may discourage acquisition proposals and may delay, deter or prevent a change of control of our company, including through transactions, and in particular through unsolicited transactions, which could have a material adverse effect on our ability to enter into transactions that some or all of our stockholders find favorable.

In addition, in our settlement with the Civil Division, we agreed to pay $35.0 million in the event that we are acquired or otherwise experience a change in control on or before April 30, 2015, provided the transaction meets certain criteria specified in the settlement agreement.

Our stock price and trading volume may be volatile and future sales of our common stock could adversely affect the trading price of our common stock.

From time to time, the price and trading volume of our common stock, as well as the stock of other companies in the health care industry, may experience periods of significant volatility. Company-specific issues and developments generally in the health care industry (including the regulatory environment) and the capital markets and the economy in general may cause this volatility. Our stock price and trading volume may fluctuate in response to a number of events and factors, including:

- variations in our operating results;
- changes in our or the market's expectations about our future operating results;
- changes in financial estimates and recommendations by securities analysts concerning our Company or the health care industry generally;
- operating and stock price performance of other companies that investors may deem comparable;
- news reports relating to trends in our markets;
- changes or proposed changes in the laws, regulations and policies affecting our business;
- acquisitions and financings by us or others in our industry;
- changes in our senior management;
- sales of substantial amounts of our common stock by our directors and executive officers or principal stockholders, or the perception that such sales could occur; and
- the risks described in "Risks Related to Our Business" above.

We may issue equity securities in the future, including securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. We have an effective shelf registration statement on Form S-3 filed with the SEC under which we may offer from time to time an indeterminate amount of any combination of debt securities, common and preferred stock and warrants. The registration statement allows us to seek additional financing, subject to the SEC's rules and regulations relating to eligibility to use Form S-3. Debt financing, if available, may involve restrictive covenants.

The issuance of additional shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Holders of shares of our common stock have no preemptive rights that entitle them to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 100,000,000 shares of common stock and 20,000,000 shares of preferred stock.

Risks Related to Information Technology

If we are unable to maintain effective and secure management information systems and applications, successfully update or expand processing capability or develop new capabilities to meet our business needs we could experience operational disruptions and other materially adverse consequences to our business and results of operations.

Our business depends on effective and secure information systems, applications and operations. The information gathered, processed and stored by our management information systems assists us in, among other things, marketing and sales and membership tracking, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, and planning and analysis. These systems also support our customer service functions, provider and member administrative functions and support tracking and extensive analysis of medical expenses and outcome data. These systems remain subject to unexpected interruptions resulting from occurrences such as hardware failures or increased demand. There can be no assurance that such interruptions will not occur in the future, and any such interruptions could have a material adverse effect on our business and results of operations. Moreover, operating and other issues can lead to data problems that affect the performance of important functions, including, but not limited to, claims payment, customer service and financial reporting.

There can also be no assurance that our process of improving existing systems, developing new systems to support our operations, complying with contractual data requirements and improving service levels will not be delayed or that system issues will not arise in the future. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems, difficulty in improving quality, increases in administrative expenses and write-offs of our expenditures in unsuccessful capital investments.

Additionally, events outside our control, including terrorism or acts of nature such as hurricanes, earthquakes, or fires, could significantly impair our information systems, applications and critical business functions. To help ensure continued operations in the event that our primary operations are rendered inoperable, we have a disaster recovery plan to recover critical business functionality within stated timelines. Our plan may not operate effectively during an actual disaster and our operations and critical business functions could be disrupted, which would have a material adverse effect on business and our results of operations.

Our costs to comply with laws governing the transmission, security and privacy of health information could be significant, and any disruptions or security breaches in our information technology systems could have a material adverse effect on our business, cash flows, operating results or financial condition.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and client data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems or those of our providers or regulators, which could disrupt our operations or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches.

Failure to keep our computer networks, information technology systems, computers and programs and our members' and customers' sensitive information secure from attack, damage or unauthorized access, whether as a result of our action or inaction or that of one of our business associates or other vendors, could adversely affect our reputation, membership and revenues and also expose us to mandatory disclosure to the media, contract termination, litigation (including class action litigation), and other enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special,

punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our business, cash flows, operating results or financial condition.

Our measures to prevent security breaches may not be successful. As we expand our business, including through acquisitions and organic growth, increase the amount of information we make available to members and consumers on mobile devices and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage or unauthorized access, increases, and the cost of attempting to protect against these risks also increases.

The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), one part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), modified certain provisions of the Health Insurance Portability and Accountability Act ("HIPAA") by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic health records, expanding enforcement mechanisms, and increasing penalties for violations. Civil penalties for HIPAA violations by covered entities are up to an annual maximum of $1.5 million for uncorrected violations based on willful neglect. HHS is required to conduct periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties became mandatory in February 2011, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

In addition, the HITECH Act requires us to notify affected individuals, HHS, and in some cases the media when unsecured personal health information is subject to a security breach.

The HITECH Act also contains a number of provisions that provide incentives for states to initiate certain programs related to health care and health care technology, such as electronic health records. While provisions such as these do not apply to us directly, states wishing to apply for grants under the HITECH Act, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

On January 25, 2013, HHS, as required by the HITECH Act, issued the Final Omnibus Rules that provide final modifications to HIPAA rules to implement the HITECH Act. The various requirements of the HITECH Act have different compliance dates, some of which have passed and some of which will occur in the future. We will continue to assess our compliance obligations as regulations under HIPAA as modified by the HITECH Act continue to become effective and more guidance becomes available from HHS and other federal agencies. The evolving privacy and security requirements, however, may require substantial operational and systems changes, associate education and resources and there is no guarantee that we will be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the evolving regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under the HITECH Act and may require us to incur significant costs in order to seek to comply with its requirements.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

HHS has released rules pursuant to HIPAA which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. By October 1, 2015, the federal government will require that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions. These new standardized code sets, known as ICD-10, has required and will continue to require substantial investments from health care organizations, including us. While use of the ICD-10 code sets will require significant administrative changes, the cost of compliance with these regulations has not had and we do not expect it to have a material adverse effect on our cash flows, financial position or results of operations. However, these changes may result in errors and otherwise negatively impact our service levels, and we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our principal administrative, sales and marketing facilities are located at our leased corporate headquarters in Tampa, Florida. Our corporate headquarters is used in all of our lines of business. As of December 31, 2014, we also leased office space for the administration of our health plans in Arizona, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Missouri, New Jersey, New York, Ohio, South Carolina, Tennessee, Texas and Washington. These properties are all in good condition and are well maintained. We believe these facilities are suitable and provide the appropriate level of capacity for our current operations. Upon expiration of the terms of the leases, we believe we could renew these leases on acceptable terms, or find suitable space elsewhere.

Item 3. Legal Proceedings.

United States Department of Health and Human Services

In April 2011, we entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years. The Corporate Integrity Agreement requires various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, our reporting practices and bid submissions to federal health care programs.

If we fail to comply with the terms of the Corporate Integrity Agreement we may be required to pay certain monetary penalties. Furthermore, if we commit a material breach of the Corporate Integrity Agreement, OIG-HHS may exclude us from participating in federal health care programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and have a material adverse effect on our results of operations.

Other Lawsuits and Claims

Separate and apart from the legal matter described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and cash flows.

Item 4. Mine Safety Disclosures.

Not Applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market for Common Stock

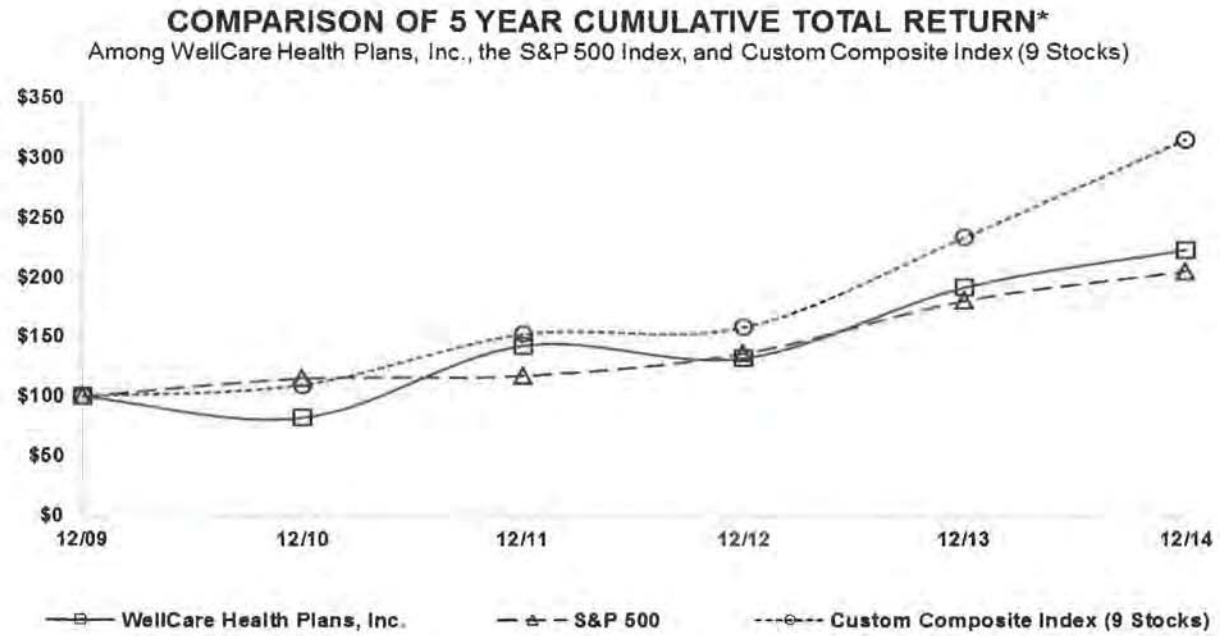
Our common stock is listed on the New York Stock Exchange under the symbol "WCG." The following table sets forth the high and low sales prices of our common stock, as reported on the New York Stock Exchange, for each of the periods indicated:

	High	Low
2014		
First Quarter ended March 31, 2014	$ 73.44	$ 55.16
Second Quarter ended June 30, 2014	**$ 78.37**	**$ 61.47**
Third Quarter ended September 30, 2014	$ 77.78	$ 59.71
Fourth Quarter ended December 31, 2014	**$ 84.69**	**$ 55.43**
2013		
First Quarter ended March 31, 2013	**$ 61.13**	**$ 44.75**
Second Quarter ended June 30, 2013	$ 64.29	$ 50.41
Third Quarter ended September 30, 2013	**$ 71.34**	**$ 55.12**
Fourth Quarter ended December 31, 2013	$ 75.31	$ 60.05

The last reported sale price of our common stock on the New York Stock Exchange on February 13, 2015 was $82.32. As of February 13, 2015, we had approximately 22 holders of record of our common stock.

Performance Graph

The following graph compares the cumulative total stockholder return on our common stock for the period from December 31, 2009, to December 31, 2014 with the cumulative total return on the stocks included in the Standard & Poor's 500 Stock Index and the custom composite index over the same period. The Custom Composite Index includes the stock of Aetna Inc., Anthem Inc. (formerly known as WellPoint Inc.), Centene Corp., Cigna Corp., Health Net Inc., Humana Inc., Molina Healthcare, Inc., UnitedHealth Group Inc. and Universal American Corp. The graph assumes an investment of $100 made in our common stock and the custom composite index on December 31, 2009. The graph also assumes the reinvestment of dividends and is weighted according to the respective company's stock market capitalization at the beginning of each of the periods indicated. We did not pay any dividends on our common stock during the period reflected in the graph. Further, our common stock price performance shown below should not be viewed as being indicative of future performance.



	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014
WellCare Health Plans, Inc.	$ 100	$ 82	$ 143	$ 132	$ 192	$ 223
S&P 500 Index	$ 100	$ 115	$ 117	$ 136	$ 180	$ 205
Custom Composite Index (9 stocks)	$ 100	$ 110	$ 152	$ 158	$ 233	$ 316

Dividends

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the foreseeable future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. In addition, our credit agreement and indenture have certain restrictions on our ability to pay dividends. Any future determination to pay dividends will be at the discretion of our board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 – *Management's Discussion and Analysis of Financial Condition and Results of Operations – Regulatory Capital and Restrictions on Dividends*.

Unregistered Issuances of Equity Securities

None.

Issuer Purchases of Equity Securities

We do not have a stock repurchase program. Additionally, for the majority of restricted stock units granted, the number of shares issued on the date the units vest is net of shares withheld to meet applicable tax withholding requirements. Although these withheld shares are not issued or considered common stock repurchases under a stock repurchase program, they are treated as common stock repurchases in our financial statements as they reduce the number of shares that would have been issued upon vesting.

Item 6. Selected Financial Data.

The following table sets forth our summary financial data. This information should be read in conjunction with our consolidated financial statements and the related notes and "*Management's Discussion and Analysis of Financial Condition and Results of Operations*"included elsewhere in this 2014 Form 10-K. The data for the years ended December 31, 2014, 2013 and 2012, and as of December 31, 2014 and 2013, is derived from consolidated financial statements and related notes included elsewhere in this 2014 Form 10-K.

	For the Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In millions, except per share data)				
Revenues:					
Premium:					
Medicaid Health Plans	$ 7,572.8	$ 5,585.5	$ 4,389.0	$ 3,505.3	$ 3,252.4
Medicaid premium taxes	76.5	75.7	82.2	76.2	56.4
Medicaid state ACA industry fee reimbursement	124.6	—	—	—	—
Total Medicaid Health Plans	7,773.9	5,661.2	4,471.2	3,581.5	3,308.8
Medicare Health Plans	3,963.2	3,071.0	1,936.4	1,479.8	1,336.1
Medicare PDPs	1,178.4	776.9	992.6	1,036.8	785.3
Total premium	12,915.5	9,509.1	7,400.2	6,098.1	5,430.2
Investment and other income	44.4	18.8	8.8	8.7	10.0
Total revenues	12,959.9	9,527.9	7,409.0	6,106.8	5,440.2
Expenses:					
Medical benefits:					
Medicaid Health Plans	6,853.1	4,927.4	3,892.0	2,890.1	2,888.5
Medicare Health Plans	3,506.9	2,659.5	1,630.6	1,198.8	1,067.2
Medicare PDPs	1,095.2	671.7	781.3	859.1	638.8
Total medical benefits	11,455.2	8,258.6	6,303.9	4,948.0	4,594.5
Selling, general and administrative (1)	1,018.8	856.5	690.8	642.1	838.0
ACA industry fee	137.7	—	—	—	—
Medicaid premium taxes	76.5	75.7	82.2	76.2	56.4
Depreciation and amortization	59.9	44.1	31.6	26.4	23.9
Impairment and other charges (2)	24.1	—	—	—	—
Interest (3)	39.4	11.9	4.1	6.5	0.2
Total expenses	12,811.6	9,246.8	7,112.6	5,699.2	5,513.0
Income (loss) from operations	148.3	281.1	296.4	407.6	(72.8)
Bargain purchase gain (4)	29.5	—	—	—	—
(Loss) gain on extinguishment of debt (5)	—	(2.8)	—	10.8	—
Income (loss) before income taxes	177.8	278.3	296.4	418.4	(72.8)
Income tax expense (benefit)	114.1	103.0	111.7	154.2	(19.4)
Net income (loss)	$ 63.7	$ 175.3	$ 184.7	$ 264.2	$ (53.4)
Net income (loss) per share:					
Basic	$ 1.45	$ 4.03	$ 4.29	$ 6.17	$ (1.26)
Diluted	$ 1.44	$ 3.98	$ 4.22	$ 6.10	$ (1.26)

	For the Years Ended December 31,				
	2014	2013	2012	2011	2010
Operating Statistics:					
Medical benefits ratio:					
Medicaid Health Plans, including premium taxes	88.2%	87.0%	87.0%	80.7%	87.3%
Medicaid Health Plans (6)	90.5%	88.2%	88.7%	82.4%	88.8%
Medicare Health Plans	88.5%	86.6%	84.2%	81.0%	79.9%
Medicare PDPs	92.9%	86.5%	78.7%	82.9%	81.4%
SG&A ratio, including premium taxes	7.9%	9.1%	9.4%	10.5%	15.4%
SG&A ratio (7)	8.0%	9.0%	9.4%	10.6%	15.6%
Membership:					
Medicaid Health Plans	2,310,000	1,759,000	1,587,000	1,451,000	1,340,000
Medicare Health Plans	417,000	290,000	213,000	135,000	116,000
Medicare PDPs	1,392,000	797,000	869,000	976,000	768,000
Consolidated	4,119,000	2,846,000	2,669,000	2,562,000	2,224,000

	As of December 31,				
	2014	2013	2012	2011	2010
	(In millions)				
Balance Sheet Data:					
Cash and cash equivalents	$ 1,313.5	$ 1,482.5	$ 1,100.5	$ 1,325.1	$ 1,359.5
Total assets	4,495.0	3,450.7	2,675.5	2,488.1	2,247.3
Long-term debt (including current maturities)	900.0	600.0	135.0	146.3	—
Total liabilities	2,899.1	1,932.8	1,352.4	1,371.3	1,415.2
Total stockholders' equity	1,595.9	1,517.9	1,323.1	1,116.9	832.1

(1) Selling, general and administrative ("SG&A") expense includes $37.6 million, $57.3 million, $51.6 million, $47.0 million and $265.9 million for the years ended December 31, 2014, 2013, 2012, 2011, and 2010, respectively, of aggregate costs related to the resolution of the previously disclosed governmental and Company investigations, such as settlement accruals and related fair value accretion, legal fees and other similar costs. The 2010 costs are net of $25.8 million of D&O insurance recoveries related to the consolidated securities class action during this period.

(2) We recognized approximately $24.1 million in impairment and other charges, $18.0 million of which primarily relates to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice. The remaining charges also include a charge for the full impairment of intangible assets associated with the purchase of our Arizona MA plan after we concluded during 2014 to exit the Arizona MA market in 2015, and charges resulting from the resolution of certain matters related to the purchase price of our 2013 acquisitions.

(3) Interest expense for 2014 includes interest related to the $300 million term loan funded in September 2014, as well as interest related to $600 million 5.75% senior notes (the "Senior Notes") issued in November 2013. Interest expense for 2013 includes interest related to the Senior Notes, as well as the term loans borrowed under the 2011 Credit Agreement. A portion of the net proceeds from the issuance of the Senior Notes was used to pay off the remaining $336.5 million term loan balance under the 2011 Credit Agreement in November 2013.

(4) The estimated fair value of the net tangible and intangible assets that we acquired in connection with the Windsor acquisition has exceeded the total consideration paid, and payable, to the seller by approximately $29.5 million. We recognized the excess fair value as a bargain purchase gain, in accordance with accounting rules related to business combinations, after consideration of all relevant factors.

(5) The 2013 loss relates to the acceleration of approximately $2.8 million of deferred financing costs associated with the early payoff of the term loan outstanding under our 2011 Credit Agreement discussed above. The 2011 gain relates to the December 15, 2011 repurchase of all of the $112.5 million tradable unsecured subordinated notes we issued on September 30, 2011 in connection with the stipulation and settlement agreement, which was approved in May 2011, to resolve the putative class-action complaints filed against us in 2007.

(6) Medical benefits ratio ("MBR") measures the ratio of our medical benefits expense to premium revenue excluding reimbursement for Medicaid premium taxes and Medicaid state ACA industry fee reimbursement revenue. Because reimbursements for Medicaid premium tax and ACA industry fee impacts are both included in the premium rates or reimbursement established in certain of our Medicaid contracts and also recognized separately as a component of expense, we exclude these reimbursements from premium revenue when calculating key ratios as we believe that their impact is not indicative of operating performance. For GAAP reporting purposes, Medicaid premium taxes and Medicaid state ACA industry fee reimbursements are included in premium revenue.

(7) SG&A expense ratio measures selling, general and administrative expense as a percentage of total revenue, excluding premium taxes and Medicaid state ACA industry fee reimbursements, and does not include depreciation and amortization expense for purposes of determining the ratio.

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the foreseeable future.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

(In Millions, Except Per Share Data or As Otherwise Stated)

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6 – *Selected Financial Data* and our consolidated financial statements and related notes appearing elsewhere in this 2014 Form 10-K. The following discussion contains forward-looking statements that involve risks, uncertainties and assumptions that could cause our actual results to differ materially from management's expectations. Factors that could cause such differences include those set forth under Part I, Item 1 – *Business* and Part I, Item 1A – *Risk Factors*, as well as *Forward-Looking Statements* discussed earlier in this 2014 Form 10-K.

OVERVIEW

Introduction

We are a leading managed care company for government-sponsored health care coverage with a focus on Medicaid and Medicare programs. Headquartered in Tampa, Florida, we offer a variety of managed care health plans for families, children, and the aged, blind and disabled, as well as prescription drug plans. As of December 31, 2014, we served approximately 4.1 million members in 49 states and the District of Columbia. We estimate that we are among the 10 largest Medicaid providers of managed care services plans, and among the 10 largest providers of Medicare Advantage ("MA") plans and prescription drug plans ("PDPs"), all as measured by membership. We believe that our broad range of experience and exclusive government focus allows us to effectively serve our members, partner with our providers and government clients, and efficiently manage our ongoing operations.

Summary of Consolidated Financial Results

Summarized below are the key financial highlights for the year ended December 31, 2014. For additional information, refer to the "Results of Operations" section which discusses both consolidated and segment results in more detail.

- ***Membership*** increased 45% in 2014, mainly driven by organic membership growth across all of our segments, primarily in our Medicaid Health Plans and Medicare PDPs segments, as well as the acquisition of Windsor Health Group, Inc. ("Windsor"), which was completed on January 1, 2014. The Windsor acquisition accounted for increases of 80,000 and 103,000, in our Medicare Health Plans and Medicare PDPs segments, respectively. Excluding Windsor, consolidated membership at December 31, 2014 increased 38% year over year.

- ***Premiums*** increased 36% in 2014, driven mainly by the increases in membership discussed above. The Windsor acquisition accounted for combined increases in Medicare and Medicare PDP segment revenue of $620.5 million for 2014. Additionally, the increase was driven by the net impact of ACA industry fee reimbursement from our Medicaid state customers and Medicaid membership mix changes, partially offset by rate decreases in our Medicare segment and a lower rate in our Medicare PDPs segment, consistent with our 2014 bids.

- ***Net Income*** declined 64% in 2014 due mainly to an increase in the medical benefit ratios for all three of our segments, the impact of unreimbursed ACA industry fees, increased interest expense from higher debt levels in 2014 and the recognition of $24.1 million in impairment and other charges, primarily related to Easy Choice Health Plan Inc. ("Easy Choice"). Partially offsetting these reductions was the increase in premiums from organic growth, lower administrative expenses as a percentage of total revenues and the $29.5 million we recognized from the Windsor bargain purchase gain.

Key Developments and Accomplishments

Our current business priorities include improving health care quality and access for our members, optimizing financial performance, delivering prudent and profitable growth and achieving service excellence. See Part I, Item 1 – *Business* for further discussion of our business priorities.

Presented below are key developments and accomplishments relating to progress on our business priorities that occurred or impacted our financial condition and results of operations during 2014, or occurred in 2015 prior to the filing of this 2014 Form 10-K.

- In January 2014, we acquired all of the outstanding stock of Windsor from Munich Health North America, Inc., a part of Munich Re Group. Through its subsidiaries, Windsor serves Medicare beneficiaries with MA, PDP and Medicare Supplement products. As of December 31, 2014, Windsor offered MA plans to 37,000 members in 192 counties in the states of Arkansas, Mississippi, South Carolina and Tennessee. In addition, one of Windsor's subsidiaries offers

Medicare Supplement insurance policies through which it serves approximately 43,000 members in 39 states as of December 31, 2014. Windsor also offers PDPs in 11 of the 34 CMS regions to 103,000 members as of December 31, 2014.

- In February 2014, we executed a contract with the Florida Agency for Health Care Administration ("AHCA") to provide managed care services to Medicaid recipients in eight of the state's 11 regions as part of the state's Managed Medical Assistance ("MMA") program. The program commenced on May 1, 2014, with the implementation of three regions. Three additional regions were implemented in June, one in July and one in August. We are serving over 650,000 members in these regions as of December 31, 2014, compared to 394,000 members that we served in December 2013 under the prior Florida Medicaid program.

- Effective January 1, 2014, we began offering Medicaid managed care in Essex, Hudson, Middlesex, Passaic and Union counties in New Jersey. In addition, effective July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst Health Plan of New Jersey, Inc. ("Healthfirst NJ"), which primarily relate to approximately 42,000 Healthfirst Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as certain provider agreements. As a result, effective July 1, 2014, we offer Medicaid managed care in 10 counties in New Jersey.

- We have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014 and 2015. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue in the year ended December 31, 2014.

- Medicare Health Plans segment membership as of January 1, 2015, was 380,000, a 9% decrease from 417,000 as of December 31, 2014. The approximate decrease of 37,000 members was driven by actions taken in conjunction with our 2015 bids and county withdrawals in California designed to improve the performance of Easy Choice, which resulted in a 28,000 member decrease in California, as well as the Company's exit from the Missouri, Ohio, and Arizona markets representing 8,000 members as of December 31, 2014. For 2015, WellCare offers Medicare Advantage plans in 376 counties across 15 states.

- In October 2014, the Centers for Medicare & Medicaid Services ("CMS") announced 2015 MA and PDP quality ratings, known as star ratings, which reflected improvement for several of WellCare's plans. The star rating for our Florida plan, which serves approximately 31% of our January 2015 MA membership, maintained its rating of 3.5 stars for 2015. Our California plan, which serves approximately 10% of our January 2015 MA membership, improved its star rating from 3 to 3.5.

- Due to changes in our bid design based on our 2014 experience, our 2015 PDP bids resulted in one of our basic plans being below the benchmarks in 13 of the 33 CMS regions for which we submitted bids, and within the de minimis range in nine other regions. However, the outcome of our 2015 bids is expected to have a favorable impact on 2015 gross margin results compared to 2014. For 2014, our basic plan was below the benchmarks in 30 regions, of the 33 regions bid, and within the de minimis range in two other regions.

- In October 2014, WellCare received NCQA Quality Accreditation for its Medicaid and Medicare health plans in Georgia, Kentucky and Missouri.

General Economic and Political Environment and Health Care Reform

Please refer to Part I, Item 1 – *Business, General Economic and Political Environment Impacting our Business* and *Health Care Reform* for a further discussion of the current economic and political environment that is affecting our business, including discussion of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") and its potential impact on our business.

The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers which began in 2014. The total ACA industry fee levied on the health insurance industry was $8 billion in 2014 and will be $11.3 billion in 2015, with increasing annual amounts thereafter, growing to $14.3 billion by 2018. After 2018, the industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S. health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. We incurred $137.7 million of such fees in 2014 and currently estimate that we will incur between $230 and $235 million in such fees in 2015, due to the increase in the

total fee to be levied on the industry and the expected increase in our share of total industry premiums for 2014. However, the 2015 final fee amount will not be determined until August 2015. We have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014. We have also obtained similar commitments from our Medicaid customers for 2015. CMS does not directly reimburse us for the impact of the ACA industry fee related to MA and PDP premiums. Refer to the risks and uncertainties related to health care reform as discussed in Part I, Item 1A – *Risk Factors – Future changes in health care law present challenges for our business that could have a material adverse effect on our results of operations and cash flows.*

RESULTS OF OPERATIONS

Consolidated Financial Results

The following table sets forth condensed data from our consolidated statements of operations data, as well as other key data used in our results of operations discussions for the years ended December 31, 2014, 2013 and 2012. The historical results are not necessarily indicative of results to be expected for any future period.

	For the Years Ended December 31,		
	2014	2013	2012
Revenues:	(Dollars in millions)		
Premium	$ 12,915.5	$ 9,509.1	$ 7,400.2
Investment and other income	44.4	18.8	8.8
Total revenues	12,959.9	9,527.9	7,409.0
Expenses:			
Medical benefits	11,455.2	8,258.6	6,303.9
Selling, general and administrative	1,018.8	856.5	690.8
ACA industry fee	137.7	—	—
Medicaid premium taxes	76.5	75.7	82.2
Depreciation and amortization	59.9	44.1	31.6
Interest	39.4	11.9	4.1
Impairment and other charges	24.1	—	—
Total expenses	12,811.6	9,246.8	7,112.6
Income from operations	148.3	281.1	296.4
Bargain purchase gain	29.5	—	—
Loss on extinguishment of debt	—	(2.8)	—
Income before income taxes	177.8	278.3	296.4
Income tax expense	114.1	103.0	111.7
Net income	$ 63.7	$ 175.3	$ 184.7
Membership by Segment			
Medicaid Health Plans	2,310,000	1,759,000	1,587,000
Medicare Health Plans	417,000	290,000	213,000
Medicare PDPs	1,392,000	797,000	869,000
Total	4,119,000	2,846,000	2,669,000

Membership

2014 vs. 2013

Membership increased 45% in 2014, mainly driven by organic membership growth across all of our segments, primarily in our Medicaid Health Plans and Medicare PDPs segments, as well as the Windsor acquisition, which was completed on January 1, 2014. Membership discussion by segment follows:

- *Medicaid Health Plans.* Medicaid Health Plans segment membership increased by 551,000, or 31% year over year, to 2.3 million as of December 31, 2014, primarily driven by organic membership growth in our Florida, Georgia and Kentucky Medicaid programs. Florida membership increased mainly due to our participation in the Managed Medical Assistance ("MMA") program, which commenced implementation on May 1, 2014, while Kentucky membership increased mainly due to Kentucky's participation in the 2014 Medicaid expansion. Additionally, 42,000 members were transferred to our Medicaid plan in New Jersey as a result of the Healthfirst acquisition.

- *Medicare Health Plans.* Medicare Health Plans segment membership increased by 127,000, or 44% year over year, to 417,000 as of December 31, 2014. Membership increased primarily from the Windsor acquisition, which contributed approximately 37,000 MA and 43,000 Medicare Supplement program members as of December 31, 2014, as well as an increase resulting from the 2014 annual election period due to our continued focus on dual-eligible beneficiaries and expansion into new counties.

- *Medicare PDPs.* Medicare PDPs segment membership as of December 31, 2014 increased by 595,000, or 75%, compared to December 31, 2013 as a result of the outcome of our 2014 bids, as well as the inclusion of membership from the Windsor acquisition, which accounted for 103,000 of the increase.

2013 vs. 2012

At December 31, 2013, we served approximately 2,846,000 members; an increase of 177,000, or 7%, from 2,669,000 members at December 31, 2012. The growth in 2013 was mainly driven by acquisitions and organic membership growth in our Medicaid Health Plans and Medicare Health Plans segments, partially offset by a decline in Medicare PDPs membership. Membership discussion by segment follows:

- *Medicaid Health Plans. S*egment membership increased by approximately 172,000 compared to December 31, 2012, primarily driven by our acquisitions of plans in South Carolina and Missouri in 2013, which contributed 50,000 and 104,000 members to the year-over-year increase, respectively, as well as membership growth in our Florida and Kentucky Medicaid programs. Kentucky Medicaid membership increased 85,000 compared to 2012, including approximately 57,000 members that were transferred to us following a competitor's exit from the Kentucky market in July 2013 and 13,000 beneficiaries from Region 3 which we began serving effective January 1, 2013. These increases were partially offset by a decline of approximately 97,000 members resulting from our exit from Ohio, which was effective July 1, 2013.

- *Medicare Health Plans.* Segment membership increased by approximately 77,000 compared to December 31, 2012, due mainly to the results of the 2013 annual election period, which resulted in an increase of approximately 37,000 members effective January 1, 2013 due to our geographic expansion into 53 new counties in Florida, Georgia, Illinois, Kentucky, New York, and Texas.

- *Medicare PDPs.* Segment membership decreased by approximately 72,000 compared to December 31, 2012 as a result of our 2013 PDP bids, which resulted in the reassignment to other plans, effective January 1, 2013, of members who were auto-assigned to us in 2012 or prior years.

Net income

2014 vs. 2013

For the year ended December 31, 2014, our net income was $63.7 million compared to $175.3 million for the same period in 2013. The $111.6 million, or 64%, decrease was mainly due to higher medical benefits ratios in all of our segments, including the recognition of unfavorable prior year reserve development in 2014, which mainly impacted our Medicaid and Medicare Health Plans segments, compared to favorable prior year reserve development in 2013; the impact of unreimbursed ACA industry fees; increased interest expense from higher debt levels in 2014; and the recognition of $24.1 million in impairment and other charges, primarily related to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice Health Plan, Inc. ("Easy Choice"). These decreases were partially offset by the increase in premiums from organic membership growth and acquisitions, lower administrative expenses as a percentage of total revenues and the Windsor bargain purchase gain, which amounted to $29.5 million in 2014. Refer to *Segment Reporting* below for a discussion of current developments, operating results and other key performance measures by reportable segment.

2013 vs. 2012

For the year ended December 31, 2013, our net income was $175.3 million compared to $184.7 million for the same period in 2012. The $9.4 million, or 5%, decrease was mainly driven by the impact of lower favorable development in prior year

medical benefits payable, lower results in our Medicare PDPs segment, consistent with lower membership, and increased interest expense and other costs resulting from higher average debt levels in 2013 associated with additional borrowings in February 2013 and November 2013, partially offset by increased premium revenue in our Medicaid and Medicare Health Plans segments resulting from the membership increases noted above. Refer to *Segment Reporting* below for a discussion of current developments, operating results and other key performance measures by reportable segment.

Premium revenue

2014 vs. 2013

Premium revenue for the year ended December 31, 2014 increased approximately $3.4 billion, or 36%, compared to the same period in 2013, due mainly to the impact of organic membership growth across all of our segments and the Windsor acquisition, which accounted for combined increases in Medicare and PDP segment revenue of $620.5 million for the year ended December 31, 2014. Additionally, the increase was due to the impact of the ACA fee reimbursement from our Medicaid state customers, the favorable impact of Medicaid membership mix changes and the benefit of a full year of premiums for our South Carolina and Missouri Medicaid plans that were acquired in the first quarter of 2013. These increases were partially offset by rate decreases in our Medicare Health Plans segment and a lower rate in our Medicare PDPs segment, consistent with our 2014 bids.

2013 vs. 2012

Premium revenue for the year ended December 31, 2013 increased approximately $2.1 billion, or 28%, compared to the same period in 2012. The increase is primarily attributable to our 2012 and 2013 acquisitions, which collectively contributed $913.4 million, or 12%, to the year-over-year increase, organic membership growth in our Medicaid and Medicare Health Plans segments and rate increases in certain of our Medicaid markets, including the 7% increase in Kentucky that was effective January 1, 2013. Additionally, the increase was partially attributable to Medicaid revenue from payment arrangements with certain states associated with primary care enhanced payments, as mandated by the ACA. These increases were partially offset by the impact of lower membership in our Medicare PDPs segment. Premium revenue included $75.7 million and $82.2 million of Medicaid premium taxes for the years ended December 31, 2013 and 2012, respectively.

2015 Outlook

Excluding Medicaid premium taxes and ACA industry fee reimbursement, premium revenue for 2015 is expected to increase to approximately $13.5 billion to $13.8 billion, primarily driven by growth in our Medicaid Health Plans segment.

Investment and other income

2014 vs. 2013

Investment and other income in 2014 was $44.4 million, a $25.6 million increase from $18.8 million in 2013, primarily driven by the Windsor acquisition, as well as higher volumes of prescription drug plan copayments and specialty prescription drugs sold to non-members.

2013 vs. 2012

Investment and other income in 2013 was $18.8 million, a $10.0 million increase from $8.8 million in 2012, primarily driven by higher volumes of prescription drug plan copayments and specialty prescription drugs sold to non-members.

2015 Outlook

We expect that Investment and other income will decline to approximately $15 to $20 million in 2015, due mainly to the outsourcing of our pharmacy mail order operations and a reduction in member copayments. We expect that the decline will be more than offset by expected decreases in selling, general and administrative expense, and prescription drug cost savings resulting from the outsourcing.

Medical benefits expense

2014 vs. 2013

Total medical benefits expense for the year ended December 31, 2014 increased $3.2 billion, or 39% compared to the same period in 2013, due primarily to increased membership across all our segments, and higher current period medical and

pharmacy costs, including higher medical costs associated with the Florida MMA program, which operated at a medical benefits ratio ("MBR") that was higher than our 2013 performance in the state. Also contributing to the higher expense was unfavorable prior year reserve development in 2014, which was due to higher than expected medical services in our Medicaid and Medicare Health Plan segments that were not discernible until the impact became clearer over time as claim payments were processed. For the year ended December 31, 2014, medical benefits expense was impacted by approximately $48.1 million of unfavorable prior year reserve development compared to $3.0 million of favorable prior year reserve development recognized in 2013.

2013 vs. 2012

Total medical benefits expense for the year ended December 31, 2013 increased $2.0 billion, or 31%, compared to the same period in 2012. The increase was due mainly to the increased membership in the Medicaid and Medicare Health Plans segments, including acquisitions, the impact of lower favorable development in prior year medical benefits payable, increased medical expense in the first quarter of 2013 associated with the flu and Medicaid primary care enhanced payments, as mandated by the ACA, partially offset by a decrease in the Medicare PDP segment due to lower membership. For the year ended December 31, 2013, medical benefits expense was impacted by approximately $3.0 million of favorable prior year reserve development compared to $76.7 million of such development recognized in 2012.

Selling, general and administrative expense

SG&A expense includes aggregate costs related to the resolution of the previously disclosed governmental investigations and related litigation, such as settlement accruals and related fair value accretion, legal fees and other similar costs. Refer to Note 13–*Commitments and Contingencies* within the Consolidated Financial Statements for additional discussion of investigation-related litigation and other resolution costs. We believe it is appropriate to evaluate SG&A expense exclusive of these investigation-related litigation and other resolution costs because we do not consider them to be indicative of long-term business operations.

A reconciliation of SG&A expense, including and excluding investigation-related costs, is presented below.

	For the Years Ended December 31,		
	2014	2013	2012
	(In millions)		
SG&A expense	$ 1,018.8	$ 856.5	$ 690.8
Adjustments:			
Investigation-related litigation and other resolution costs	(1.4)	(2.5)	(3.9)
Investigation-related administrative costs	(36.2)	(54.8)	(47.7)
Total investigation-related litigation and other resolution costs	(37.6)	(57.3)	(51.6)
SG&A expense, excluding investigation-related litigation and other resolution costs	$ 981.2	$ 799.2	$ 639.2
SG&A ratio [1]	7.9%	9.1%	9.4%
Adjusted SG&A ratio [2]	7.7%	8.5%	8.7%

(1) SG&A expense, as a percentage of total premium revenue.

(2) SG&A expense, as a percentage of total premium revenue, excluding premium taxes, Medicaid state ACA industry fee reimbursements and investigation-related litigation and other resolution costs.

2014 vs. 2013

Excluding investigation-related litigation and other resolution costs, our SG&A expense for the year ended December 31, 2014 increased approximately 23%, to $981.2 million. SG&A expense increased mainly due to the growth in membership, investments in technology and infrastructure, including costs necessary to meet regulatory changes, investments related to our medical cost initiatives, increased spending related to the integration of recent acquisitions and our other growth and service initiatives. These cost increases were partially offset by improvements in operating efficiency. Our SG&A ratio decreased to 7.9% for the year ended December 31, 2014 compared to 9.1% for the same period in 2013. After excluding the investigation-related litigation and other resolution costs, our SG&A ratio in 2014 was 7.7% compared to 8.5% for the same period in 2013.

2013 vs. 2012

Excluding investigation-related litigation and other resolution costs, our SG&A expense for the year ended December 31, 2013 increased approximately $160.0 million, or 25%, to $799.2 million compared to the same period in 2012. The increase was driven mainly by the growth in membership, investments in technology and infrastructure, including costs necessary to meet regulatory changes, investments related to our medical cost initiatives and increased SG&A from the integration of acquisitions. Additionally, during the third quarter of 2013, we determined that we would be discontinuing certain projects going forward and, as a result, the software and development costs acquired to support these projects would not be fully recoverable. Consequently, we recorded a pre-tax asset impairment charge of $9.0 million. The increase in costs in 2013 noted above were partially offset by improvements in operating efficiency. Our SG&A ratio was 9.1% for the year ended December 31, 2013 compared to 9.4% for the same period in 2012. After excluding the investigation-related litigation and other resolution costs, our SG&A ratio in 2013 was 8.5% compared to 8.7% for the same period in 2012.

2015 Outlook

Our adjusted administrative expense ratio for 2015 is expected to be between approximately 8.0% and 8.2%, an increase from 7.7% in 2014. The expected increase is driven mainly by continued investments and re-establishment of variable compensation that was eliminated in 2014 due to financial and other performance criteria not meeting targets.

ACA Industry Fee

2014

For the year ended December 31, 2014, we incurred $137.7 million of non-deductible expense for the ACA industry fee, based on our share of total health insurance industry assessment. As discussed in *Key Developments and Accomplishments*, we currently have received amendments, written agreements or other documentation from all of our state Medicaid customers that commit them to reimburse us for substantially all of the impact of the ACA industry fee attributable to our Medicaid plans, including its non-deductibility for income tax purposes for 2014.

2015 Outlook

Currently, we estimate that we will incur between $230 and $235 million total ACA industry fees in 2015, due to the increase in the total fee to be levied on the industry and the expected increase in our share of total industry premiums for 2014. However, the 2015 final fee amount will not be determined until August 2015.

Medicaid premium taxes

2014 vs. 2013

Medicaid premium taxes incurred for the year ended December 31, 2014 were $76.5 million compared to $75.7 million for the same period in 2013. In 2014, Medicaid premiums related to our Medicaid contracts with Georgia, Hawaii, New Jersey and New York were subject to premium taxes.

2013 vs. 2012

Medicaid premium taxes incurred for the year ended December 31, 2013 were $75.7 million compared to $82.2 million for the same period in 2012. The year-over-year decline of approximately $6.5 million, or 8%, was primarily driven by our exit from the Ohio Medicaid market, which was effective July 1, 2013.

Depreciation and Amortization

2014 vs. 2013

Depreciation and amortization expense increased approximately $15.8 million, or 36%, to $59.9 million in 2014 from $44.1 million in 2013. The increase in the 2014 periods compared to 2013 is due primarily to incremental amortization related to the intangible assets acquired in conjunction with the Windsor acquisition, which was completed on January 1, 2014, and the Healthfirst NJ acquisition completed on July 1, 2014. Additionally, amortization for the year ended December 31, 2014 was impacted by a full year of amortization related to the Missouri Care and WellCare of South Carolina, Inc. ("WCSC") acquisitions, which were completed during the first quarter of 2013.

2013 vs. 2012

Depreciation and amortization expense increased approximately $12.5 million, or 40%, to $44.1 million in 2013 from $31.6 million in 2012, which included approximately $5.9 million of incremental amortization recorded during 2013 relating to the intangible assets acquired in conjunction with the Desert Canyon, Easy Choice, Missouri Care and WCSC acquisitions. The remaining increase is primarily attributable to incremental infrastructure related investments made during 2013.

2015 Outlook

Depreciation and amortization for 2015 is expected to increase to approximately $70 to $72 million, primarily driven by increased investments in our information technology infrastructure.

Interest expense

2014 vs. 2013

Interest expense for the year ended December 31, 2014 was $39.4 million compared to $11.9 million for the same period in 2013. The $27.5 million increase was primarily driven by higher average debt levels during 2014, as we borrowed an additional $300 million term loan (the "Term Loan") under the current credit agreement in September 2014 and, additionally, issued $600 million of 5.75% senior notes (the "Senior Notes") in November 2013.

2013 vs. 2012

Interest expense for the year ended December 31, 2013 was $11.9 million compared to $4.1 million for the same period in 2012. The $7.8 million increase was primarily driven by higher average debt levels during 2013, as we borrowed an additional $230 million in term loans under the 2011 credit agreement in February 2013 and, additionally, issued the Senior Notes in November 2013. A portion of the net proceeds from the issuance of the senior notes was used to payoff the remaining term loan balance under the 2011 credit agreement.

2015 Outlook

We expect that interest expense will increase in 2015 compared to 2014, due to higher average debt outstanding from the issuance of the Term Loan in September 2014, and is anticipated to be between $47 and $49 million.

Impairment and other charges

During the second quarter of 2014, we recognized approximately $24.1 million in impairment and other charges, $18.0 million of which primarily relates to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice. The impairment resulted primarily from estimated fair values of the intangible assets that were below the book values of such assets. The estimated fair values of these assets were determined based on an income valuation approach using assumptions appropriate for likely market participants. The estimated fair values reflect a significant decline in anticipated long-term profitability, mainly resulting from an inability to improve the medical cost structure to the degree that was previously estimated and the inability to achieve certain administrative cost savings, as a result of certain developments during the second quarter. The remaining charges also include a charge for the full impairment of intangible assets associated with the purchase of our Arizona MA plan after we concluded during 2014 to exit the Arizona MA market in 2015, and charges resulting from the resolution of certain matters related to the purchase price of our 2013 acquisitions. We were no longer able to recognize such charges as adjustments to acquired assets, since we were beyond the measurement period established in the accounting rules for business combinations.

Bargain Purchase Gain

As a result of the Windsor acquisition, the estimated fair value of the net tangible and intangible assets that we acquired has exceeded the total consideration payable to the seller by approximately $29.5 million for the year ended December 31, 2014. After consideration of all relevant factors, we concluded that the excess fair value constituted a bargain purchase gain in accordance with accounting rules related to business combinations.

Loss on extinguishment of debt

2013

In November 2013, a portion of the net proceeds from the issuance of $600 million of 5.75% senior notes was used to pay off the remaining $336.5 million term loan balance, plus accrued interest, and we then terminated our 2011 credit agreement. In conjunction with the extinguishment of debt, we incurred approximately $2.8 million for the accelerated recognition of previously deferred financing costs. For further information regarding the 2013 debt transactions, refer to Note 12 –*Debt* within the Consolidated Financial Statements.

Income tax expense

2014 vs. 2013

Income tax expense for the year ended December 31, 2014 was $114.1 million, or 64.2% of pre-tax income, compared to $103.0 million, or 37.0% of pre-tax income, for the year ended December 31, 2013. The higher 2014 effective rate mainly reflects the impact of the non-deductible ACA industry fee. Additionally, the effective rate was lower in 2013 due to an issue resolution agreement reached with the IRS regarding the tax treatment of the investigation-related litigation and other resolution costs, resulting in approximately $7.6 million in additional tax benefit over what was recorded as of December 31, 2012. These unfavorable impacts were partially offset by the favorable impact of the Windsor bargain purchase gain.

2013 vs. 2012

Income tax expense for the year ended December 31, 2013 was $103.0 million, or 37.0% of pre-tax income, compared to $111.7 million, or 37.7% of pre-tax income, for the year ended December 31, 2012. The lower effective income tax rate in 2013 is primarily due to an issue resolution agreement reached with the Internal Revenue Service during 2013 regarding the tax treatment of certain investigation-related litigation and other resolution cost, which resulted in the recognition of approximately $7.6 million in income tax benefits during the first quarter of 2013, partially offset by the impact of non-deductible compensation under certain provisions of the Affordable Care Act, which generally limits deductions on executive compensation earned after December 31, 2009 that is paid after December 31, 2012.

2015 Outlook

We expect that our effective tax rate will increase in 2015 compared to 2014 due mostly to the expected increase in non-deductible ACA industry fees in proportion to the projected earnings increase in 2015.

Segment Reporting

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the enterprise's decision-makers to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs.

Segment Financial Performance Measures

In conjunction with the Windsor acquisition, we reassessed our segment reporting practices during the three months ended March 31, 2014, and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of Medicare Supplement and Medicare Advantage operations acquired as part of the Windsor acquisition together with MA. Accordingly, we include results for Medicare Supplement operations together with MA and renamed the segment Medicare Health Plans. Similarly, we include the PDP operations acquired as part of the Windsor acquisition together with WellCare's PDPs and renamed the segment Medicare PDPs. No changes were made to the composition of our Medicaid segment, but we renamed the segment Medicaid Health Plans.

Our primary tools for measuring profitability of our reportable operating segments are premium revenue, gross margin and MBR. Beginning in 2014, the ACA imposes an annual premium-based health insurance industry fees on health insurers. Since the timing of revenue recognition for state Medicaid reimbursement of the ACA industry fee has been delayed and has not matched the expense recognition of the fee, and MA and PDP rates will not be adjusted for the ACA industry fee, we have determined to include the ACA industry fee expense in measuring the profitability of our reportable operating segments. Accordingly, gross margin has been redefined as premium revenue less medical benefits expense, less ACA industry fees. MBR measures the ratio of medical benefits expense to premium revenue excluding Medicaid premium taxes and Medicaid state ACA industry fee reimbursement.

We use gross margin and MBR both to monitor our management of medical benefits and medical benefits expense and to make various business decisions, including which health care plans to offer, which geographic areas to enter or exit and which health care providers to include in our networks. Although gross margin and MBR play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk sharing, would likely lower our exposure to variability in medical costs or for other reasons.

Changes in gross margin and MBR from period to period depend in large part on our ability to, among other things, effectively price our medical and prescription drug plans, estimate and manage medical costs and changes in estimates related to incurred but not reported claims ("IBNR"), estimate and effectively manage medical benefits expense relative to the primarily fixed premiums we receive, negotiate competitive rates with our health care providers, and attract and retain members. In addition, factors such as changes in health care laws, regulations and practices, changes in Medicaid and Medicare funding, changes in the mix of membership, escalating health care costs, competition, levels of use of health care services, general economic conditions, major epidemics, terrorism or bio-terrorism, new medical technologies, including the new, expensive hepatitis C drugs, and other external factors may affect our operations and may have a material adverse impact on our business, financial condition and results of operations.

For further information regarding premium revenues and medical benefits expense, please refer below to "*Premium Revenue Recognition and Premiums Receivable*", and "*Medical Benefits Expense and Medical Benefits Payable*" under "*Critical Accounting Estimates.*"

Reconciling Segment Results

The following table reconciles our reportable segment results with our income from operations (before income taxes), as reported in accordance with accounting principles generally accepted in the United States of America ("GAAP").

	For the Years Ended December 31,		
	2014	2013	2012
Gross Margin:	(In millions)		
Medicaid Health Plans	$ 839.2	$ 733.8	$ 579.2
Medicare Health Plans	411.6	411.5	305.8
Medicare PDPs	71.8	105.2	211.3
Total gross margin	1,322.6	1,250.5	1,096.3
Investment and other income	44.4	18.8	8.8
Other expenses	(1,218.7)	(988.2)	(808.7)
Income from operations	$ 148.3	$ 281.1	$ 296.4

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and other state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Program ("CHIP"), Family Health Plus ("FHP") and Managed Long-Term Care ("MLTC") programs. As of December 31, 2014, we operated Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, New Jersey, New York and South Carolina. We began serving South Carolina members on February 1, 2013, Missouri Care members on April 1, 2013 and New Jersey members on January 1, 2014. As of July 1, 2013, we no longer provided Medicaid services in Ohio.

Impacting Our Results

- Effective May 1, 2014, we began providing managed care services to Medicaid recipients in three regions as part of Florida's MMA program. Three additional regions were implemented in June, one in July and one in August, completing the implementation in all eight regions we serve. As of December 31, 2014, we were serving over 650,000 members in these regions, compared to the 394,000 members that we served in December 2013. Our anticipated Florida MMA premium is higher than our historical experience to compensate us for the enhanced benefits and services required in the MMA program, however, we have also incurred higher medical expense compared to our previous expectations, reflecting slower than anticipated medical expense improvement during the initial months of

this program. Consistent with past implementation of new programs, we are pursuing improvements to care management and expect to pursue increased reimbursement in order to enhance the financial performance of the MMA program. Care management improvements include improving reimbursement terms and collaboration models in certain of our provider contracts, terminating certain providers when we could not achieve an appropriate cost structure or an agreement to collaborate, adding clinical resources into the local health plan, and embedding nurses in some high volume facilities.

- Effective January 1, 2014, our Kentucky program began serving new members associated with Kentucky's 2014 ACA Medicaid expansion. Such membership totaled 117,000 as of December 31, 2014.

- Effective January 1, 2014, we began offering Medicaid managed care in Essex, Hudson, Middlesex, Passaic and Union counties in New Jersey. In addition, effective July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst NJ, which primarily relate to the approximate 42,000 Healthfirst Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as to certain provider agreements that transferred to us. As a result, effective July 1, 2014, we offer Medicaid managed care in 10 counties in New Jersey.

- We have received amendments, written agreements or other documentation from all our state Medicaid customers, that commit them to reimburse us for the portion of the ACA industry fee attributable to the Medicaid programs in these states, including the related state and federal income tax gross-ups. Consequently, we recognized approximately $124.6 million in reimbursement as premium revenue in the year ended December 31, 2014.

Medicaid Segment Results

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicaid segment for the years ended December 31, 2014, 2013 and 2012:

	For the Years Ended December 31,		
	2014	2013	2012
	(In millions)		
Premium revenue (1)	$ 7,572.8	$ 5,585.5	$ 4,389.0
Medicaid premium taxes (1)	76.5	75.7	82.2
Medicaid state ACA industry fee reimbursement (1)	124.6	—	—
Total premiums	7,773.9	5,661.2	4,471.2
Medical benefits expense	6,853.1	4,927.4	3,892.0
ACA industry fee	81.6	—	—
Gross margin	$ 839.2	$ 733.8	$ 579.2
Medicaid MBR, including premium taxes and Medicaid state ACA industry fee reimbursements	88.2%	87.0%	87.0%
Impact of:			
Medicaid premium taxes	0.9%	1.2%	1.7%
Medicaid state ACA industry fee reimbursement	1.4%	—	—
Medicaid MBR (1)	90.5%	88.2%	88.7%
Medicaid Membership:			
Florida	722,000	486,000	454,000
Georgia	604,000	540,000	570,000
Kentucky	420,000	292,000	207,000
Other states (2)	564,000	441,000	356,000
	2,310,000	1,759,000	1,587,000

(1) MBR measures the ratio of our medical benefits expense to premium revenue excluding reimbursement for Medicaid premium taxes and Medicaid state ACA industry fee reimbursement revenue. Because reimbursements for Medicaid premium tax and ACA industry fee impacts are both included in the premium rates or reimbursement established in certain of our Medicaid contracts and also recognized separately as a component of expense, we exclude these reimbursements from premium revenue when calculating key ratios as we believe that their impact is not indicative of operating performance. For GAAP reporting purposes, Medicaid premium taxes and Medicaid state ACA industry fee reimbursements are included in premium revenue.

(2) "All other states" consists of Hawaii, Illinois, and New York during all years presented. In 2012, it also includes Ohio; in 2013, it also includes Missouri and South Carolina; and in 2014, it also includes Missouri, New Jersey and South Carolina. Effective as of June 30, 2012, our Missouri contract expired and was not renewed. We re-entered Missouri Medicaid in March 2013 when we acquired Missouri Care. We were not awarded a Medicaid contract in Ohio for the 2013 fiscal year; however, the state of Ohio contracted with us to provide services to Ohio Medicaid beneficiaries through a transition period, which ended June 30, 2013.

2014 vs. 2013

Excluding Medicaid premium taxes and Medicaid state ACA industry fee reimbursements, Medicaid premium revenue for the year ended December 31, 2014 increased $2.0 billion, or 36%, when compared to the same period in 2013. The increase in premium revenues was driven mainly by increased membership in Florida, due to organic growth and participation in the Florida MMA program, which commenced implementation on May 1, 2014, and in Kentucky, primarily from its participation in the ACA Medicaid expansion and the additional members received following a competitor's exit from the Kentucky program in 2013. Also contributing to the increase in revenue was the net favorable impact of changes in the geographic and demographic mix of members, higher per member per month ("PMPM") rates related to the Florida MMA membership and growth in New Jersey resulting from expansion and the Healthfirst acquisition. The increase for the year ended December 31, 2014 also reflects the benefit of a full year's membership from the South Carolina and Missouri Care Medicaid acquisitions completed during the first quarter of 2013. These increases were partially offset by our exit from the Ohio Medicaid program effective July 1, 2013.

Medical benefits expense for the year ended December 31, 2014 increased by approximately 39%, when compared to the same period in 2013, mainly driven by the increase in membership, higher current period medical and pharmacy costs, and higher medical costs associated with for the Florida MMA program, which operated at a higher MBR than our 2013 performance in the state. The increase for the year ended December 31, 2014 also reflects recognition of unfavorable prior year reserve development and a full year's membership from the South Carolina and Missouri Medicaid acquisitions completed during the first quarter of 2013. Our Medicaid Health Plan segment MBR, excluding the impact of premium taxes and ACA industry fee reimbursement, increased by 230 basis points for the year ended December 31, 2014 compared to 2013, due to the impact of higher current period medical and pharmacy costs, higher cost associated with the Florida MMA program and unfavorable prior year reserve development recognized in 2014 compared to favorable prior year reserve development recognized in 2013. Pharmacy costs include increased spending on hepatitis C drugs as a result of the new, expensive drugs approved in 2014 as well as other pharmacy cost increases.

2013 vs. 2012

Excluding Medicaid premium taxes, Medicaid premium revenue for the year ended December 31, 2013 increased $1.2 billion, or 27%, when compared to the same period in 2012. The South Carolina and Missouri acquisitions increased premium revenue by $380.2 million, or 9%, year-over-year, while the remaining $816.3 million, or 18% increase was driven primarily by increased membership in our Kentucky and Florida programs, a 7% rate increase in Kentucky that was effective on January 1, 2013, rate increases in certain other markets in late 2012, changes in geographic and demographic mix of members and Medicaid revenue from payment arrangements with certain states associated with primary care enhanced payments, as mandated by the ACA. The increase in Kentucky Medicaid membership and premiums also reflect the commencement of services provided to beneficiaries in Region 3, which began on January 1, 2013, as well as the additional members received from following a competitor's exit from the Kentucky Medicaid market in July 2013.

Medicaid medical benefits expense for the year ended December 31, 2013 increased 27%, which is consistent with the increase in membership and premiums. Our Medicaid MBR for the year ended December 31, 2013 decreased by approximately 50 basis points when compared to the same period in 2012, mainly reflecting the impact of improved results in Kentucky, partially offset by a lower amount of favorable development of prior years' medical benefits payable in 2013 compared to 2012. The Kentucky program MBR declined to 90.0% in 2013 compared to 105.1% in 2012, as 2012 performance was adversely impacted by relatively high transitional medical benefit expenses for the program which launched in late 2011. The Missouri and South Carolina acquisitions also contributed to the decrease in the Medicaid segment MBR in 2013, as the MBR for these programs was lower than the segment average.

2015 Outlook

- We anticipate Medicaid segment premium revenue, excluding premium taxes and the Medicaid state ACA industry fee reimbursement, to increase to approximately $8.5 to $8.7 billion in 2015. The increase primarily results from a full year contribution from Florida MMA revenue, the New Jersey managed long-term services and supports product and the New York integrated duals program implementation.
- We currently expect our Medicaid segment MBR in 2015 to be in the range of approximately 89.25% to 90.25%, excluding the impact of Medicaid premium taxes and the Medicaid state ACA industry fee reimbursement, compared to 90.5% percent in 2014, with the largest driver being continued progress in the Florida MMA business. As discussed

in *Impacting our Results*, we expect continued margin improvement in the Florida MMA program through our performance improvement plan, including applying managed care fundamentals to the MMA population, and collaboration with the state to ensure actuarial soundness.

- We have obtained amendments, written agreements and other documentation from our Medicaid customers to reimburse us for the impact of the industry fee on our Medicaid plans for 2015, including its non-deductibility for income tax purposes.

Medicare Health Plans

We contract with CMS under the Medicare program to provide a comprehensive array of Part C and Part D benefits to Medicare eligible persons, provided through our MA plans. Our MA plans are comprised of coordinated care plans ("CCPs"), which are administered through HMOs and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of most of our MA plans.

In 2014, we operated our MA CCPs in 18 states, including Arkansas, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Mississippi, Missouri, New Jersey, New York, Ohio, South Carolina, Tennessee and Texas. We cover a wide spectrum of medical services through our MA plans. For many of our plans, we provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, out-of-pocket expenses incurred by our members are generally reduced, which allows our members to better manage their health care costs.

As of December 31, 2014, we also offered Medicare Supplement policies in 39 states.

Impacting Our Results

- Our MA business was subjected to substantial margin compression in 2014. As a result of legislation passed in December 2013, the 2% Federal budget sequestration reduction to Medicare provider and plan payments continued in 2014 and will extend through 2023, and our results of operations were and will continue to be negatively impacted. In addition, CMS implemented revised 2014 benchmark rates, which resulted in a rate decrease of approximately 2.0% to 4.0% from 2013 rates. CMS also made changes to the MA and PDP Medicare risk adjustment system involving a risk coding recalibration, which is being phased in over the 2014 and 2015 plan years. The new risk adjustment model included an adjustment to the calculation of health status cost risk based on each beneficiary's diagnosis codes that will reduce the positive adjustments for high-risk patients and increase the negative adjustments for low-risk patients. The change appears to most severely affect our rates for those individuals with complex medical conditions, including many of our dual-eligible and lower income members. Also, CMS implemented an MA coding intensity reduction of 4.91% from 3.41% for payment year 2014. Our MA premium rates have not been adjusted to specifically offset the impact of the ACA industry fee.

- We gained approximately 37,000 MA members in 192 counties, in the states of Arkansas, Mississippi, South Carolina and Tennessee, as a result of the Windsor acquisition. In addition, one of Windsor's subsidiaries offered Medicare Supplement insurance policies and served approximately 43,000 members in 39 states as of December 31, 2014.

Medicare Health Plans Segment Results

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare Health Plans segment for the years ended December 31, 2014, 2013 and 2012:

	For the Years Ended December 31,		
	2014	2013	2012
	(In millions)		
Premium revenue	$ 3,963.2	$ 3,071.0	$ 1,936.4
Medical benefits expense	3,506.9	2,659.5	1,630.6
ACA industry fee	44.7	—	—
Gross margin	$ 411.6	$ 411.5	$ 305.8
Medicare Health Plans Membership	417,000	290,000	213,000
Medicare Health Plans MBR	88.5%	86.6%	84.2%

2014 vs. 2013

Medicare premium revenue in 2014 increased $892.2 million, or 29%, when compared to the same period in 2013. The Windsor acquisition contributed approximately $507.2 million, or 17%, to the year-over-year increase, while organic membership growth in Florida, California, New York and Texas drove the remaining increase. Partially offsetting these increases was the impact of CMS premium rate decreases compared to 2013.

Medical benefits expense for the year ended December 31, 2014 increased $847.4 million, or 32%, compared to the same period in 2013, mainly driven by the increase in membership discussed above. The Medicare Health Plans segment MBR increased by 190 basis points compared to 2013, resulting mainly from the impact of CMS rate decreases and the federal government's budget sequestration, which took effect in April 2013, as well as unfavorable prior year reserve development, partially offset by changes to plan benefit designs and cost sharing terms in 2014 compared with 2013, as well as our ongoing medical cost management initiatives.

2013 vs. 2012

Medicare Health Plans premium revenue for the year ended December 31, 2013 increased $1.1 billion, or 59%, when compared to the same period in 2012. The Easy Choice and Desert Canyon acquisitions contributed $533.2 million, or 27%, to the year-over-year growth, while the remaining $601.4 million, or 32%, increase was mainly attributable to organic membership growth associated with our service area expansion, higher risk adjusted premium, prior year revenue adjustments and the strengthening of our sales processes and our product design.

The $1.0 billion, or 63%, increase in medical benefits expense during 2013 compared to the same period in 2012 reflects the increase in membership and premiums and increase in the Medicare Health Plans segment MBR. Medicare Health Plans segment MBR increased by 240 basis points for the year ended December 31, 2013 compared to 2012 due to the impact of Easy Choice, which operated at a higher MBR relative to the segment average, our 2013 plan design and the impact of the federal government's budget sequestration, partially offset by favorable prior period revenue adjustments.

2015 Outlook

- We expect premium revenue for our Medicare Health Plans segment in 2015 to be between $3.95 billion and $4.05 billion, stable compared to 2014.
- For the Medicare Health Plans segment, we currently expect the MBR in 2015 to be in the range of approximately 85.0% to 86.5%, compared to 88.5% in 2014. The expected improvement in 2015 is due to specific actions in 2014 designed to increase focus and make progress toward a more reasonable margin, which include specific 2015 bid actions, the continuing implementation of medical expense initiatives, and the absence of 2014's unfavorable prior year reserve development.
- As of January 2015, the Company's Medicare Health Plans segment membership was approximately 380,000 members. The approximate decrease of 37,000 members was driven by actions taken in conjunction with our 2015 bid and county withdrawals in California designed to improve the performance of Easy Choice, which resulted in a 28,000 member decrease in California, as well as the Company's exit from the Missouri, Ohio, and Arizona markets representing 8,000 members as of December 31, 2014. For 2015, WellCare offers Medicare Advantage plans in 376 counties across 15 states.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDP plans to Medicare eligible beneficiaries through our Medicare PDPs segment. As of December 31, 2014, we offered PDP plans in 49 states and the District of Columbia. The PDP benefit design generally results in our incurring a greater portion of the responsibility for total prescription drug costs in the early stages of a plan year, and less in the latter stages of a plan year, due to the members' share of cumulative out-of-pocket costs increasing throughout the plan year. As a result, the Medicare PDPs MBR generally decreases throughout the year. Also, the level and mix of members who are auto-assigned to us as and those who actively choose our PDP plans will impact the segment MBR pattern across periods.

Impacting Our Results

- Our Medicare PDP business was subjected to substantial margin compression in 2014. As a result of legislation passed in December 2013, the 2% Federal budget sequestration reduction to Medicare provider and plan payments continued in 2014 and will extend through 2023, and so our results of operations have been, and will continue to be, negatively impacted. In addition, our PDP premium rates from CMS have not been adjusted to specifically offset the impact of the ACA industry fee.

- Based on the outcome of our 2014 stand-alone PDP bids, our plans were below the benchmarks in 30 of the 33 CMS regions for which we submitted bids and within the de minimis range of the benchmark in two other CMS regions. Comparatively, in 2013, our plans were below the benchmark in 14 regions and within the de minimis range in five other regions. In 2014, we were auto-assigned newly eligible members into our plans for the 30 regions that were below the benchmark. Membership increased to approximately 1,392,000 at December 31, 2014, compared to 797,000 at December 31, 2013.

Medicare PDPs Segment Results

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare PDPs segment for the years ended December 31, 2014, 2013 and 2012:

	For the Years Ended December 31,		
	2014	2013	2012
	(In millions)		
Premium revenue	**$ 1,178.4**	**$ 776.9**	**$ 992.6**
Medical benefits expense	1,095.2	671.7	781.3
ACA industry fee	**11.4**	—	—
Gross margin	$ 71.8	$ 105.2	$ 211.3
Medicare PDPs membership	1,392,000	797,000	869,000
Medicare PDPs MBR	92.9%	86.5%	78.7%

2014 vs. 2013

PDP premium revenue increased 52% in 2014 when compared to 2013, primarily due to the increase in membership, which includes 103,000 members from the Windsor acquisition, partially offset by lower premium rates resulting from our 2014 bids. PDP MBR for the year ended December 31, 2014 increased 640 basis points over the same period in 2013 and contributed to the increase in medical benefits expense. The MBR increase is mainly due to higher drug unit costs, increased utilization of branded and specialty medications, the outcome of our 2014 bids and CMS rate decreases and the federal government's budget sequestration, which took effect in April 2013.

2013 vs. 2012

PDP premium revenue decreased 22% for the year ended December 31, 2013 when compared to the same period in 2012, primarily due a decline in membership resulting from the outcome of our 2013 bids. PDP MBR for the year ended December 31, 2013 increased 780 basis points over the same period in 2012 mainly due to the addition of our new enhanced product, designed for those who choose a PDP, and a shift in membership to this product, as well as higher drug unit costs and the outcome of our 2013 bids. Transition of care costs for the enhanced product also contributed to the increased MBR. The transition period concluded at the end of March 2013.

2015 Outlook

- We anticipate that PDP segment premium revenue will decrease to approximately $1.0 to $1.1 billion in 2015, primarily as a result of a decline in membership resulting from the outcome of our 2015 bids, as discussed below.
- We currently anticipate our PDP segment MBR for 2015 will be in the range of approximately 85.5% to 87.0%, down from 92.9% in 2014. The expected year-over-year decrease results mainly from the results of our 2015 bids, which reflect a better balance of margin and membership, including an increase in our basic plan premium.
- PDP membership as of January 1, 2015 was 1,098,000, a decrease of approximately 294,000, or 21%, from 1,392,000 as of December 31, 2014. The decline in membership in 2015 is primarily based on the outcome of our 2015 PDP bids, in which our plans were below the benchmarks in 13 of the 33 CMS regions for which we submitted bids and in the de minimis range in nine regions. In 2015, those PDP members who were auto assigned to us in regions where our plans are not below or within the de minimis range were or are being assigned to other plans. However, the outcome of our 2015 bids is expected to have a favorable impact on the 2015 segment results compared to 2014, as discussed above.

LIQUIDITY AND CAPITAL RESOURCES

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. Additionally, we operate as a holding company in a highly regulated industry. The parent and other non-regulated companies ("non-regulated subsidiaries") are dependent upon dividends and management fees from our regulated subsidiaries, most of which are subject to regulatory restrictions. For a further discussion of risks that can affect our liquidity, see Part I – Item 1A – *Risk Factors* included in this 2014 Form 10-K.

Liquidity

The Company maintains liquidity at two levels: the regulated subsidiary level and the non-regulated parent and subsidiary level.

Regulated subsidiaries

Our regulated subsidiaries' primary liquidity requirements include:

- payment of medical claims and other health care services;
- management fees paid to our non-regulated administrator subsidiary under intercompany services agreements and direct administrative costs, which are not covered by an intercompany services agreement, such as selling expenses and legal costs; and
- federal tax payments to the parent company under an intercompany tax sharing agreement.

Our regulated subsidiaries meet their liquidity needs by:

- maintaining appropriate levels of cash, cash equivalents and short-term investments;
- generating cash flows from operating activities, mainly from premium revenue;
- cash flows from investing activities, including investment income and sales of investments; and
- capital contributions received from our non-regulated subsidiaries.

We refer collectively to the cash, cash equivalents and investment balances maintained by our regulated subsidiaries as "regulated cash and investments." Our regulated subsidiaries generally receive premiums in advance of payments of claims for medical and other health care services; however, regulated cash and cash equivalents can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Our unrestricted regulated cash and investments (which represent our regulated cash and investments not on deposit with a state in which we operate) was $1.7 billion as of December 31, 2014, an increase of $300 million from $1.4 billion at December 31, 2013. The increase is due mainly to cash flows from operating activities as well as $89.0 million of contributions received from our non-regulated subsidiaries, partially offset by $68.0 million in dividends distributed to our non-regulated subsidiaries.

Our regulated subsidiaries are each subject to applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our regulated subsidiaries. See further discussion under *Regulatory Capital and Dividend Restrictions* below.

Parent and non-regulated subsidiaries

Liquidity requirements at the non-regulated parent and subsidiary level generally consist of:

- payment of administrative costs not directly incurred by our regulated operations, including, but not limited to, staffing costs, business development, rent, branding and certain information technology services;
- capital contributions and advances paid to our regulated subsidiaries;
- capital expenditures;
- debt service; and
- federal tax payments.

Our non-regulated parent and subsidiaries normally meet their liquidity requirements by:

- management fees earned by our non-regulated administrator subsidiary under intercompany services agreements;
- dividends received from our regulated subsidiaries;
- collecting federal tax payments from the regulated subsidiaries;
- proceeds from issuance of debt and equity securities; and
- cash flows from investing activities, including investment income and sales of investments.

Unregulated cash, cash equivalents and investments was $89.5 million at December 31, 2014, a decrease of $405.6 million from $495.1 million at December 31, 2013. The decrease resulted mainly from funding provided to certain regulated subsidiaries for various subsidies and other payments the subsidiaries made on behalf of CMS as a Part D plan sponsor for which CMS will reimburse us. The CMS subsidies and payments include, among others, the catastrophic reinsurance subsidy and various premium and cost sharing subsidies for low income members, as well as the CMS risk corridor. Growth in our PDP and MA membership and high drug unit costs has resulted in higher subsidy payments compared with our bids and prior years, and our unregulated cash will continue to be used to fund these benefits until they are settled with CMS, which we expect to occur in the fourth quarter of 2015. Additionally, the decrease in unregulated cash reflects $89.0 million of capital contributions made to certain regulated subsidiaries and payment of certain investigation resolution costs and other related costs. These decreases were partially offset by the $298.6 million in net proceeds from the Term Loan received in September 2014 and $68.0 million of dividends received from regulated subsidiaries.

Outlook

Based on our experience in 2014, our 2015 PDP and MA bids reflected significantly higher estimates for cash outflows for the government's responsibility of the Part D benefit plan design, particularly for the catastrophic reinsurance subsidy. While the level of subsidy payments we make on behalf of CMS compared with our 2015 bids may still be significant due to the composition of our 2015 PDP membership, which reflects a higher number of dual eligible members relative to our overall population than we expected, we expect a meaningful reduction in our CMS receivable upon settling the 2014 plan year with CMS in the fourth quarter of 2015.

Auction Rate Securities

As of December 31, 2014, $32.3 million of our long-term investments were comprised of municipal note securities with an auction reset feature ("auction rate securities"), which are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities. Two auction rate securities with an aggregate fair value of $21.3 million have investment grade security credit ratings and one auction rate security with a fair value of $11.0 million has a credit rating below investment grade. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven or 35 days. As of the date of this 2014 Form 10-K, auctions have failed for our auction rate securities and there is no assurance that auctions will succeed in the future. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. The securities for which auctions have failed will continue to accrue interest at the contractual rate and be auctioned every seven or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. In addition, if the issuers are unable to successfully close future auctions and their credit ratings deteriorate, we may in the future be required to record an impairment charge on these investments.

Although auctions continue to fail, we believe we will be able to liquidate these securities without significant loss. There are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, it could take until the final maturity of the underlying securities to realize our investments' recorded value. The final maturity as of December 31, 2014 of the underlying securities could be as long as 23 years. The weighted-average life of the underlying securities for our auction rate securities portfolio is 18 years.

Cash Flow Activities

Our cash flows are summarized as follows:

	For the Years Ended December 31,		
	2014	2013	2012
	(In millions)		
Net cash provided by (used in) operating activities	$ 299.3	$ 178.9	$ (30.7)
Net cash used in investing activities	(75.6)	(290.5)	(222.8)
Net cash (used in) provided by financing activities	(392.7)	493.6	28.9
Total net (decrease) increase in cash and cash equivalents	$ (169.0)	$ 382.0	$ (224.6)

Net cash provided by (used in) operating activities

We generally receive premiums in advance of payments of claims for health care services; however, cash flows related to our operations can fluctuate significantly in a particular period depending on the timing of premiums receipts from our government partners or payments related to the resolution of government investigations and related litigation.

2014 vs. 2013

Cash provided by operating activities for 2014 was $299.3 million compared to $178.9 million for 2013, mainly resulting from an increase in premiums associated with the growth in membership, as well as the timing of certain premium receipts, partially offset by the $137.7 million ACA industry fee payment remitted to the IRS during September 2014. Operating cash flows for 2014 and 2013 also reflect payments of approximately $36.5 million and $37.6 million, respectively, made to the Civil Division under the terms of the settlement agreement discussed in "Financial Impact of Government Investigation and Litigation" below.

2013 vs. 2012

Cash provided by operating activities in 2013 was $178.9 million compared to cash used in operating activities of $30.7 million for 2012. The year-over-year improvement primarily resulted from the increase in premiums associated with the growth in membership. Operating cash flows in 2013 and 2012 also reflect payments made to the Civil Division of approximately $37.6 million and $39.8 million, respectively.

Net cash used in investing activities

2014 vs. 2013

Net cash used in investing activities for 2014 was $75.6 million compared to $290.5 million for 2013. The decrease in cash used in 2014 primarily resulted from a higher amount of cash used in acquisitions in 2013 relative to 2014, including $133.6 million advanced in December 2013 in connection with the Windsor acquisition, which closed in January 2014. Conversely, in 2014 cash flows reflect $48.0 million of net cash acquired from acquisitions. Excluding acquisitions, investment activities primarily reflect our investment in marketable securities and restricted investments, purchases of property and equipment and proceeds from maturities of marketable securities and restricted investments, which in combination, did not materially change year over year.

2013 vs. 2012

Net cash used in investing activities was $290.5 million in 2013 compared to $222.8 million in 2012. The increase in cash used in 2013 compared to 2012 was primarily due to the $133.6 million advanced in December 2013 in connection with the Windsor acquisition which closed in January 2014, partially offset by the impact from lower collective amounts paid in connection with the 2013 acquisitions as compared to the collective amounts paid in connection with the 2012 acquisitions.

Net cash (used in) provided by financing activities

Net cash used in financing activities was $392.7 million in 2014, compared to net cash provided of $493.6 million and $28.9 million for 2013 and 2012, respectively. These cash flows mainly reflect:

- Net funds paid for the benefit of members of approximately $687.9 million for 2014, compared to funds received of $34.0 million and $36.3 million during 2013 and 2012, respectively. These funds represent the net amounts of subsidies received from CMS and the related prescription drug benefits we paid in connection with the low-income cost sharing, catastrophic reinsurance and coverage gap discount components of the Medicare Part D program related to the government's portion of financial responsibility. The increased cash outflows in 2014 are due mainly to increased drug costs relative to our MA and PDP bids.
- Aggregate net proceeds of $298.6 million in 2014 resulting from the $300.0 million Term Loan issued during September 2014, compared to aggregate net proceeds from debt transactions of $451.4 million in 2013. Debt-related activity in 2013 includes net proceeds of $228.5 million received in connection with the second amendment to our 2011 credit agreement and $587.9 million of net proceeds from the issuance of the Senior Notes in November 2013, partially offset by $28.5 million of payments made on the term loan under our 2011 credit agreement during the first three quarters of 2013. During November 2013, we used a portion of the net proceeds from the issuance of the Senior Notes to pay off the remaining $336.5 million term loan balance under our 2011 credit agreement, plus accrued interest, and used the remaining net proceeds for general corporate purposes and organic growth opportunities.

Financial Impact of Government Investigation and Litigation

Under the terms of settlement agreements entered into on April 26, 2011, and finalized on March 23, 2012, to resolve matters under investigation by the Civil Division and certain other federal and state enforcement agencies (the "Settlement"), WellCare agreed to pay the Civil Division a total of $137.5 million in four equal annual principal payments, plus interest accrued at 3.125%. The estimated fair value of the discounted remaining liability was $35.2 million at December 31, 2014.

The Settlement also provides for a contingent payment of an additional $35.0 million in the event that we are acquired or otherwise experience a change in control on or before April 30, 2015, provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Settlement.

We currently maintain directors' and officers' liability insurance in the amount of $125.0 million for other matters not addressed above.

Capital Resources

Credit Agreement

In September 2014, we amended and restated our existing credit agreement (as amended and restated, the "Credit Agreement") to provide for the $300.0 million Term Loan, in addition to the previously-existing $300.0 million senior unsecured revolving loan facility (the "Revolving Credit Facility"), which may be used for general corporate purposes of the Company and its subsidiaries. The Revolving Credit Facility provides that up to $75.0 million may be used for letters of credit. The Credit Agreement also provides that we may, at our option, increase the aggregate amount of the Revolving Credit Facility and/or obtain incremental term loans in an amount up to $75.0 million without the consent of any lenders not participating in such increase, subject to certain customary conditions and lenders committing to provide the increase in funding. The Term Loan matures in full in September 2016, with no amortization payments or prepayment penalties. We are not able to reborrow amounts repaid under the Term Loan. The commitments under the Revolving Credit Facility expire on November 14, 2018 and any amounts outstanding under the facility will be payable in full at that time. Borrowings under the Credit Agreement bear interest at a rate of LIBOR plus a spread of between 1.50% and 2.625%, or a rate equal to the Prime Rate plus a spread of between 0.50% to 1.625%, depending upon our cash flow leverage ratio (which is defined as the ratio of our total debt to total consolidated EBITDA.) Unutilized commitments under the Credit Agreement are subject to a fee of 0.25% to 0.45% depending upon our cash flow leverage ratio.

The Credit Agreement contains negative and financial covenants that limit certain activities of our company and its subsidiaries, including (i) restrictions on our ability to incur additional indebtedness; and (ii) financial covenants that require (a) the cash flow leverage ratio not to exceed a maximum; (b) a minimum interest expense and principal payment coverage ratio; and (c) 105% of our required level of statutory net worth for our health maintenance organization and insurance subsidiaries. The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Revolving Credit Facility. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required immediately to repay all amounts outstanding under the Credit Agreement. Lenders holding at least 50% of the loans and commitments under the Credit Agreement may elect to accelerate the maturity of the loans and/or terminate the commitments under the Credit Agreement upon the occurrence and during the continuation of an event of default.

We received net proceeds of $298.6 million in connection with the funding of the Term Loan and the closing of the Credit Agreement in September 2014. The Term Loan is classified as long-term debt in the Company's consolidated balance sheet at December 31, 2014 based on its September 2016 maturity date. The interest rate on the Term Loan was 2.5% as of December 31, 2014.

Additionally, in November 2013, we terminated our 2011 credit agreement in connection with our entry into the Credit Agreement described above. All amounts outstanding under the 2011 credit agreement were paid in full on November 14, 2013.

As of December 31, 2014 and as of the date of this filing, we have not drawn upon the Revolving Credit Facility and we remain in compliance with all covenants under both the Credit Agreement and the Senior Notes (defined below).

Senior Notes

In November 2013, we completed the offer and sale of $600.0 million in principal amount of 5.75% unsecured Senior Notes due 2020. We received net proceeds of $587.9 million upon issuance of the Senior Notes, after deduction of approximately $12.1 million incurred in debt issuance costs. The Senior Notes will mature on November 15, 2020, with interest

on the Senior Notes payable semi-annually on May 15 and November 15 of each year, which commenced on May 15, 2014. We used a portion of the net proceeds from the offering to repay the full $336.5 million outstanding under our 2011 credit agreement, and the remaining net proceeds are being used for general corporate purposes, including organic growth opportunities and potential acquisitions.

The indenture under which the Senior Notes were issued contains covenants that, among other things, limit the ability of our company and its restricted subsidiaries to:

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;
- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;
- incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, and in the case of our subsidiaries, guarantee indebtedness;
- engage in transactions with affiliates;
- create unrestricted subsidiaries; and
- merge or consolidate with other entities.

For additional information on our long-term debt, see Note 12 – *Debt* to the Consolidated Financial Statements.

Shelf Registration Statement

In August 2012, we filed a shelf registration statement on Form S-3 with the SEC that became automatically effective covering the registration, issuance and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, depository shares, securities purchase contracts, units or warrants. We may publicly offer securities in the future at prices and terms to be determined at the time of the offering.

Initiatives to Increase Our Unregulated Cash

We may pursue alternatives to raise additional unregulated cash. Some of these initiatives may include, but are not limited to, obtaining dividends from certain of our regulated subsidiaries, provided sufficient capital in excess of regulatory requirements exists in these subsidiaries, utilizing the Revolving Credit Facility, and/or accessing the debt and equity capital markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for additional dividends to our non-regulated subsidiaries by our regulated subsidiaries or be successful in accessing the capital markets if we determine to do so. We believe that we have sufficient capital, or sufficient access to capital, including through the Revolving Credit Facility, to meet our capital needs for at least the next twelve months.

Regulatory Capital and Dividend Restrictions

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, risk-based capital ("RBC") requirements or other financial ratios. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners ("NAIC"), and have been adopted by most states. The statutory framework for our regulated subsidiaries' minimum capital requirements could change over time. For instance, RBC requirements may be adopted by more of the states in which we operate. In addition, regulators could require our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators determine that maintaining such additional statutory net worth is in the best interest of our members and other constituencies. Failure to maintain these requirements would trigger regulatory action by the state. Such statues, regulations and capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our HMO and insurance subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries that may not be transferable to us in the form of loans, advances, or cash dividends was approximately $746.0 million at December 31, 2014, and $489.0 million at December 31, 2013. The combined statutory capital and surplus of our HMO and insurance subsidiaries was $1.3 billion and $1.1 billion at December 31, 2014 and 2013, respectively, which was in compliance with the minimum capital requirements as of those dates.

Our regulated subsidiaries are also subject to restrictions on their ability to make dividend payments. Dividend restrictions vary by state, but the maximum amount of dividends which can be paid without prior approval from the applicable state is subject to restrictions relating to statutory capital, surplus and net income for the previous year. Some states require prior

approval of all dividends, regardless of amount. States may disapprove any dividend that, together with other dividends paid by a subsidiary in the prior 12 months, exceeds the regulatory maximum as computed for the subsidiary based on its statutory surplus and net income. We received $68.0 million, $147.0 million and $192.0 million in dividends from our regulated subsidiaries during the years ended December 31, 2014, 2013, and 2012, respectively. The 2014 amount included $36 million not requiring prior regulatory approval, and $32 million paid after obtaining prior regulatory approval. Under applicable regulatory requirements at December 31, 2014, the amount of dividends that may be paid through the end of 2015 by our HMO and insurance subsidiaries without prior approval by regulatory authorities is approximately $60.0 million in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

For additional information on regulatory requirements, see Note 17 – *Regulatory Capital and Dividend Restrictions* to the Consolidated Financial Statements.

Commitments and Contingencies

The following table sets forth information regarding our contractual obligations as of December 31, 2014.

	Payments due to period				
	Total	Less Than 1 Year	1 - 3 Years	3 - 5 Years	More than 5 Years
			(In millions)		
Operating leases	$ 72.4	$ 24.9	$ 28.0	$ 11.5	$ 8.0
Purchase obligations (1)	125.3	80.7	29.6	15.0	—
Amounts accrued related to investigation resolution (2)	35.2	35.2	—	—	—
Long-term debt	900.0	—	300.0	—	600.0
Interest on debt (3)	217.6	42.2	76.2	69.0	30.2
Total	$ 1,350.5	$ 183.0	$ 433.8	$ 95.5	$ 638.2

(1) Our purchase obligations include commitments under contracts for equipment leases, software maintenance and the purchase of pharmaceuticals from our pharmacy benefit manager.
(2) Based on the terms of the settlement agreement reached with the Civil Division effective as of March 23, 2012, as discussed in Note 13 – *Commitments and Contingencies* to the Consolidated Financial Statements.
(3) Represents projected interest on our 5.75% $600.0 million Senior Notes and our $300.0 million Term Loan.

We are not an obligor under or guarantor of any indebtedness of any other party; however, we may have to pay referral claims of health care providers under contract with us who are not able to pay costs of medical services provided by other providers.

OFF BALANCE SHEET ARRANGEMENTS

At December 31, 2014, we did not have any off-balance sheet financing arrangements except for operating leases as described in the table above.

CRITICAL ACCOUNTING ESTIMATES

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with GAAP. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting estimates relating to premium revenue recognition and premiums receivable, medical benefits expense and medical benefits payable, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management's most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain.

Premium Revenue Recognition and Premiums Receivable

We earn premium revenue through our participation in Medicaid, Medicaid-related and Medicare programs. Our Medicaid contracts with state agencies generally are multi-year contracts subject to annual renewal provisions. Our Medicare contracts with CMS renew annually. Our Medicare and Medicaid contracts establish fixed, monthly premium rates per member ("PMPM"), which are generally determined at the beginning of each new contract renewal period; however, premiums may be adjusted by CMS and state agencies throughout the terms of the contracts in certain cases. Premium rate changes are recognized in the period the change becomes effective, when the impact of the change in the rate is reasonably estimable, and collection is assured. Our contracts also have additional provisions as described in the sections below.

We recognize premium revenue in the period in which we are obligated to provide services to our members. We are generally paid by CMS and state agencies in the month in which we provide services. On a monthly basis, we bill members for any premiums for which they are responsible according to their respective plan. We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in the consolidated balance sheets. Unearned premiums are recognized as revenue when we provide the related services. Member premiums are recognized as revenue in the period of service. We estimate, on an on-going basis, the amount of members' billings that may not be collectible, based on our evaluation of historical trends. An allowance is established for the estimated amount that may not be collectible. In addition, we routinely monitor the collectability of specific premiums receivable from CMS and state agencies, including Medicaid receivables for obstetric deliveries and newborns and net receivables for member retroactivity and reduce revenue and premiums receivable by the amount we estimate may not be collectible.

Premium payments are based upon eligibility lists produced by CMS and state agencies. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, CMS and state agencies require us to reimburse them for premiums that we received for individuals who were subsequently determined by us, or by CMS or state agencies, to be ineligible for any government-sponsored program or to belong to a plan other than ours. Additionally, the verification of membership may result in additional premiums due to us from CMS and state agencies for individuals who were subsequently determined to belong to our plan for periods in which we received no premium for those members. We estimate the amount of outstanding retroactivity adjustments and adjust premium revenue based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. We record amounts receivable in premiums receivable, net and amounts payable in other accrued expenses and liabilities in the consolidated balance sheets.

Supplemental Medicaid Premiums

We earn, or earned, supplemental premium payments for eligible obstetric deliveries and newborns of our Medicaid members in Georgia, Illinois, Kentucky, Missouri, New York, South Carolina and, until June 30, 2013, in Ohio. Each state Medicaid contract specifies how and when these supplemental payments are earned and paid. Upon delivery of a newborn, we notify the state agency according to the contract terms. We also earn supplemental Medicaid premium payments in some states for high cost drugs and certain services such as early childhood prevention screenings. We recognize supplemental premium revenue in the period we provide related services to our members.

Medicaid Risk-Adjusted Premiums

In some instances, our Medicaid premiums are subject to risk score adjustments based on the health profile of our membership. Generally, the risk score is determined by the state agency's analysis of encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The frequency of when states adjust premiums varies, but is usually done quarterly or semi-annually on a retrospective basis. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured.

Medicaid ACA Industry Fee reimbursement

The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment on health insurers which began in 2014. As discussed in "Medicaid Segment Results- *Impacting Our Results*", we have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014.

Medicare Risk-Adjusted Premiums

CMS provides risk-adjusted payments for MA Plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which is possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We populate our models with available risk score data on our members and base risk premium adjustments on risk score data from the previous year. We are not privy to risk score data for members new to our plans in the current plan year; therefore we include assumptions regarding these members' risk scores. We periodically revise our estimates of risk-adjusted premiums as additional diagnosis code information is reported to CMS and adjust our estimates to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts. As a result of the variability of factors that determine our estimates for risk-adjusted premiums, the actual amount of the CMS retroactive payment could be materially more or less than our estimates and could have a material effect on our results of operations, financial position and cash flows. We record any changes in estimates in current operations as adjustments to premium revenue. Historically, we have not experienced significant differences between our estimates and amounts ultimately received. However, in the third quarter of 2013, we recognized risk adjusted premium received as part of the 2012 final settlement that was higher than our original estimates, mainly related to members in our California MA plan that were new to Medicare in 2012. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could materially reduce premium revenue in the year in which CMS determines a refund is required and could be material to our results of operations, financial position and cash flows.

Minimum Medical Expense and Risk Corridor Provisions

We may be required to refund certain premium revenue to state agencies and CMS under various contractual and plan arrangements. We estimate the impact of these arrangements on a monthly basis and reflect any adjustments to premium revenues in current operations. We report the estimated net amounts due to state agencies and CMS in other payables to government partners in the consolidated balance sheets.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. We estimate the amounts due to the state agencies as a return of premium based on the terms of our contracts with the applicable state agency.

Our MA and PDP prescription drug plan premiums are subject to risk sharing through the CMS Medicare Part D risk corridor provisions. The risk corridor calculation compares our actual experience to the target amount of prescription drug costs, limited to costs under the standard coverage as defined by CMS, less rebates included in our submitted plan year bid. We receive additional premium from CMS if our actual experience is more than 5% above the target amount. We refund premiums to CMS if our actual experience is more than 5% below the target amount. Based on the risk corridor provision and PDP activity-to-date, an estimated risk-sharing receivable or payable is recorded as an adjustment to premium revenue. After the close of the annual plan year, CMS performs the risk corridor calculation and any differences are settled between CMS and our plans. Historically, we have not experienced material differences between the subsequent CMS settlement amount and our estimates.

Beginning in 2014, the ACA requires the establishment of a minimum medical loss ratio ("MLR") for MA plans and Part D plans, requiring them to spend not less than 85% of premiums on medical benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. MLR is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions did not have a material impact on our results of operations in 2014.

Medicare Part D Subsidies

For qualifying low income PDP members, CMS pays for some, or all, of the member's monthly premium.

We receive certain Part D prospective subsidy payments from CMS for our MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the prospective payments and actual claims experience. The subsidy components under Part D are described below.

Low-Income Cost Sharing Subsidy (LICS)- For qualifying low income members, CMS reimburses us for all or a portion of the low income member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold.

Catastrophic Reinsurance Subsidy- CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy.

Coverage Gap Discount Subsidy (CGD)- CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members.

Catastrophic reinsurance subsidies and the low-income cost sharing subsidies represent cost reimbursements under the Medicare Part D program. We are fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to us. Therefore, amounts received for these subsidies are not considered premium revenue, and are reported, net of the subsidy benefits paid, as Funds receivable/held for the benefit of members in the consolidated balance sheets. The receipts and payments between us and CMS are presented on a net basis as financing activity in our consolidated statements of cash flows since we are essentially administering and paying the benefit subsidies on behalf of CMS. Historically, the settlement payments between us and CMS have not been materially different from our estimates. However, the balance of funds receivable from CMS grew substantially in 2014 due to increased drug costs relative to our bid estimates.

CGD subsidies advance payments are recorded as Funds receivable/held for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGD, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted Prescription Drug Event data.

For a further description of the revenue elements related to our segments, see Part I - Item 1 - Business - *OUR PRODUCT SEGMENTS.*

Estimating Medical Benefits Expense and Medical Benefits Payable

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of incurred but not reported ("IBNR") direct medical benefits expense. Medical benefits payable includes estimates for IBNR, amounts for claims fully adjudicated but not yet paid and certain medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians, pharmacy benefit managers and providers of ancillary services. Recorded direct medical expenses are reduced by the amount of pharmacy rebates earned, which are estimated based on historical utilization of specific pharmaceuticals, current utilization and contract terms. Pharmacy rebates earned but not yet received from pharmaceutical manufacturers are included in pharmacy rebates receivable in the accompanying consolidated balance sheets. Direct medical expenses may also include reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant. Also, included in direct medical expense are estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences and amounts due to contracted providers under risk-sharing arrangements. Medically-related administrative costs include preventive health and wellness, care management, case and disease management, and other quality improvement costs. Other medically-related administrative costs such as utilization review services, network and provider credentialing and claims handling costs, are recorded in selling, general, and administrative expenses.

Medical benefits payable represents amounts for claims fully adjudicated but not yet paid and estimates for IBNR. Our estimate of IBNR is the most significant estimate included in our consolidated financial statements. We determine our best estimate of the base liability for IBNR utilizing consistent standard actuarial methodologies based upon key assumptions which vary by business segment. Our assumptions include current payment experience, trend factors, and completion factors. Trend

factors in our standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

The following table provides a detail of the components of medical benefits payable:

	December 31, 2014	% of Total	December 31, 2013	% of Total
	(In millions)			
IBNR	$ 1,111.5	75%	$ 690.1	72%
Other medical benefits payable	372.3	25%	263.3	28%
Total medical benefits payable	$ 1,483.8	100%	$ 953.4	100%

The factors and assumptions that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability. This can result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee PMPM costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. Medical cost trends potentially are more volatile than other segments of the economy. Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. External factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing changes may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. We believe that the amount of medical benefits payable as of December 31, 2014 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the year ended December 31, 2014 were decreased by 1%, our net income would decrease by approximately $132.2 million. If the completion factors were increased by 1%, our net income would increase by approximately $129.2 million.

After determining an estimate of the base liability for IBNR, we make an additional estimate, also using standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than the estimated base reserve. We refer to this additional liability as the provision for moderately adverse conditions. Our estimate of the provision for moderately adverse conditions captures the potential adverse development from factors such as:

- our entry into new geographical markets;
- our provision of services to new populations such as the aged, blind and disabled;
- variations in utilization of benefits and increasing medical costs, including higher drug costs;
- changes in provider reimbursement arrangements;
- variations in claims processing speed and patterns, claims payment and the severity of claims; and
- health epidemics or outbreaks of disease such as the flu or enterovirus.

We consider the base actuarial model liability and the provision for moderately adverse conditions as part of our overall assessment of our IBNR estimate to properly reflect the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Differences between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known and have the effect of increasing or decreasing the reported medical benefits expense in such periods. As discussed below, the cumulative effect of prior year reserve development in 2014 and 2013 was an unfavorable $48.1 million and a favorable $3.0 million, respectively, however, we recognized unfavorable prior periods reserve development in three of four quarters in 2013, and in the first and second quarters of 2014. Based on the unfavorable prior period reserve development experience in these quarters, we refined certain of these assumptions, resulting in increased current period medical benefits costs incurred.

The following table provides a reconciliation of the beginning and ending balance of medical benefits payable:

	Years Ended December 31,		
	2014	2013	2012
	(In millions)		
Balances as of beginning of period	$ 953.4	$ 733.0	$ 744.8
Acquisitions	107.0	71.6	—
Medical benefits incurred related to:			
Current year	11,481.4	8,333.2	6,450.5
Prior year	(26.2)	(74.6)	(146.6)
Total	11,455.2	8,258.6	6,303.9
Medical benefits paid related to:			
Current year	(10,089.6)	(7,490.6)	(5,754.9)
Prior year	(942.2)	(619.2)	(560.8)
Total	(11,031.8)	(8,109.8)	(6,315.7)
Balances as of end of year	$ 1,483.8	$ 953.4	$ 733.0

Medical benefits payable recorded at December 31, 2014, 2013 and 2012 developed favorably by approximately $26.2 million, $74.6 million and $146.6 million in 2014, 2013 and 2012, respectively. A portion of the prior period development was attributable to the release of the provision for moderately adverse conditions, which is included as part of the assumptions. The release of the provision for moderately adverse conditions was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the change in the amount of the incurred claims related to prior years in the Medical benefits payable does not directly correspond to an increase in net income recognized during the period.

Medical benefits expense for the year ended December 31, 2014 was impacted by approximately $48.1 million of unfavorable prior year reserve development, mainly due to higher than expected medical services in our Medicaid and Medicare Health Plan segments that were not discernible until the impact became clearer over time as claim payments were processed, while 2013 and 2012 were impacted by approximately $3.0 million and $76.7 million, respectively, of favorable development related to prior years. The favorable development in 2013 was due mainly to the medical cost trend emerging favorably in our Medicaid segment due to lower utilization. The favorable development in 2012 was due to the medical cost trend emerging favorably, mostly in our Medicaid segment and to a lesser extent in our MA and PDP segments, primarily due to lower than projected utilization, partially offset by higher than expected medical services in Kentucky.

Goodwill and Other Intangible Assets

Goodwill represents the excess of the cost over the fair market value of net assets acquired. Goodwill recorded at December 31, 2014 was $263.2 million, which consisted of $152.8 million and $110.4 million attributable to our Medicaid and Medicare Advantage reporting segments, respectively. Goodwill recorded at December 31, 2013 was $236.8 million, which consisted of $126.8 million and $110.0 million attributable to our Medicaid and Medicare Advantage reporting segments, respectively.

We test goodwill for impairment at the reporting unit level at least annually, or more frequently if events or circumstances indicate that it would be more likely than not that the fair value of a reporting unit is below its carrying value. Such events or circumstances could include a significant adverse change in business climate, an adverse action or assessment by a regulator, unanticipated competition and the testing for recoverability of a significant asset group within a reporting unit, among others. To determine whether goodwill is impaired, we compare an estimate of the fair value of the applicable reporting unit to its

carrying value, including goodwill. If the carrying value exceeds the estimated fair value, we compare the implied fair value of the applicable goodwill to its carrying value to measure the amount of goodwill impairment, if any. We perform our annual goodwill impairment test based on our financial position and results of operations as of June 30 of each year, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting and planning process. The annual impairment tests are based on an evaluation of estimated future discounted cash flows. The estimated discounted cash flows are based on the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense. Based on the results of our annual impairment testing in 2014, we determined that the fair value of each reporting unit substantially exceeded its carrying value and no goodwill impairment losses were recognized.

Other intangible assets resulting from our previous acquisitions include provider networks, broker networks, trademarks, state contracts, non-compete agreements, licenses and permits. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. These assets are allocated to reporting segments for impairment testing purposes. We review our other intangible assets for impairment when events or changes in circumstances occur, which may potentially affect the estimated useful life or recoverability of the remaining balances of our intangible assets. Such events and changes in circumstances would include significant changes in membership, state funding, federal and state government contracts and provider networks. Upon such an occurrence, recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to current forecasts of undiscounted future net cash flows expected to be generated by the assets. Identifiable cash flows are measured at the lowest level for which they are largely independent of the cash flows of other groups of assets and liabilities. If these assets are determined to be impaired, the amount of impairment recognized is measured by the amount by which the carrying amount of the assets exceeds their fair value.

During 2014, we recognized approximately $24.1 million in impairment and other charges, approximately $18.0 million of which related to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice Health Plan, Inc. ("Easy Choice"). During the year, our Easy Choice MA health plan continued to underperform, mainly reflecting an inability to improve the medical cost structure to the degree that was previously estimated, and the inability to achieve certain administrative cost savings. As a result, we performed an updated assessment of the recoverability of these intangible assets. The current projections of undiscounted future net cash flows expected to be generated by the Easy Choice health plan reflect a significant decline in the anticipated long-term profitability of this business relative to projections we completed in prior periods. The decline in projected profitability is resulting from the factors noted above, as well the continuing margin compression that is impacting the MA business as a whole. We compared the carrying values of the underlying intangible assets to the projected, undiscounted future net cash flows and determined that the undiscounted future net cash flows were insufficient to recover the carrying value of the assets. We measured the fair values of these assets at June 30, 2014 using an income-based valuation approach, and decreased the carrying values of the intangible assets to the estimated fair values, which resulted in an impairment charge of approximately $18.0 million. We believe the assumptions used in the income approach, including the projected cash flows associated with the assets, as well as other key factors and assumptions, including the selection of an appropriate discount rate, were consistent with those that likely market place participants would experience when operating in the same market, with the same membership. The remaining charges for the quarter also include a charge for the full impairment of intangible assets associated the purchase of our Arizona MA plan after we concluded during 2014 to exit the Arizona MA market in 2015, and charges resulting from the resolution of certain matters related to the purchase price of our 2013 acquisitions. We were no longer able to recognize the latter charges as adjustments to acquired assets, since we were beyond the measurement period established in the accounting rules for business combinations.

RECENTLY ADOPTED ACCOUNTING STANDARDS

Refer to Note 2 – *Summary of Significant Accounting Policies*, included in the Consolidated Financial Statements for information and disclosures related to new accounting standards which are incorporated herein by reference.

Item 7A. Qualitative and Quantitative Disclosures about Market Risk.

Investment Return Market Risk

As of December 31, 2014, we had cash and cash equivalents of $1.3 billion, investments classified as current assets of $172.8 million, long-term investments of $257.3 million and restricted investments on deposit for licensure of $150.3 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Restricted assets consist of cash and cash equivalents and U.S. Treasury instruments deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. The investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their contractual maturity dates, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2014, the fair value of our fixed income investments would decrease by approximately $3.7 million. Similarly, a 1% decrease in market interest rates at December 31, 2014 would increase the fair value of our investments by approximately $4.1 million.

Item 8. Financial Statements and Supplementary Data.

Our consolidated financial statements and related notes required by this item are set forth in the WellCare Health Plans, Inc. financial statements included in Part IV, Item 15 of this filing.

Item 9. Changes In and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

(a) ***Evaluation of Disclosure Controls and Procedures***

Management, under the leadership of our Chief Executive Officer ("CEO") and our Chief Financial Officer ("CFO"), is responsible for maintaining disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC rules and forms and that such information is accumulated and communicated to management, including our CEO and CFO, to allow timely decisions regarding required disclosures.

In connection with the preparation of this 2014 Form 10-K, our management, under the leadership of our CEO and CFO, evaluated the effectiveness of our disclosure controls and procedures ("Disclosure Controls"). Based on that evaluation, our CEO and CFO concluded that, as of December 31, 2014, our Disclosure Controls were effective in timely alerting them to material information required to be included in our reports filed with the SEC.

(b) Management's Report on Internal Control Over Financing Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as such term is defined in Rule 13a-15(f) under the Exchange Act). An evaluation was performed under the supervision and with the participation of our management, including our CEO and CFO, of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and updated in 2013 (the "COSO Framework"). Based on our evaluation under the COSO Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2014. Our independent registered public accounting firm, Deloitte & Touche, LLP, has issued an attestation report on the effectiveness of our internal control over financial reporting as of December 31, 2014, that is included herein.

(c) ***Changes in Internal Controls***

As required by Rule 13a-15(d), our management including our CEO and CFO, also conducted an evaluation of our internal control over financial reporting to determine whether any changes occurred during the quarter ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting. We implemented a change in internal control over financial reporting during the quarter ended December 31, 2014 to remediate a material weakness identified in internal controls during the quarter related to the accounting for Medicaid premium rate changes. Specifically, we completed the implementation of redesigned control processes for increased levels of review performed by our personnel in relation to this area. The material weakness related to the first three quarters of 2014. We have completed our testing of the additional control processes outlined above and conclude that the previously identified material weakness has been satisfactorily remediated as of December 31, 2014.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
WellCare Health Plans, Inc. and Subsidiaries
Tampa, Florida

We have audited the internal control over financial reporting of WellCare Health Plans, Inc. and subsidiaries (the "Company") as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedules as of and for the year ended December 31, 2014 of the Company and our report dated February 16, 2015 expressed an unqualified opinion on those financial statements and financial statement schedules.

/s/ Deloitte & Touche, LLP

Certified Public Accountants

Tampa, Florida
February 16, 2015

Item 9B. Other Information.

None

PART III

Items 10, 11, 12, 13 and 14.

The information required by Items 10, 11, 12, 13 and 14 is omitted because, no later than 120 days after December 31, 2014, we will file and distribute our definitive proxy statement for our annual meeting of stockholders containing the information required by such Items. Such omitted information is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Financial Statements and Financial Statement Schedules

(1) Financial Statements are listed in the Index to Consolidated Financial Statements on page F-1 of this report.
(2) Financial Statement Schedules are listed in the Index to Consolidated Financial Statements on Page F-1 of this report.

(b) Exhibits

For a list of exhibits to this 2014 Form 10-K, see the Exhibit Index which is incorporated herein by reference.

(c) Financial Statements

We file as part of this report the financial schedules listed on the index immediately preceding the financial statements at the end of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

WellCare Health Plans, Inc.

By: /s/ Kenneth A. Burdick
Kenneth A. Burdick
Chief Executive Officer

Date: February 17, 2015

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons in the capacities and on the dates indicated:

Signatures	Title	Date
/s/Kenneth A. Burdick **Kenneth A. Burdick**	Chief Executive Officer (Principal Executive Officer and Director)	February 17 , 2015
/s/Andrew L. Asher **Andrew L. Asher**	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 17, 2015
/s/Maurice S. Hebert **Maurice S. Hebert**	Chief Accounting Officer (Principal Accounting Officer)	February 17, 2015
/s/ David J. Gallitano **David J. Gallitano**	Chairman of the Board	February 17, 2015
/s/ Richard C. Breon **Richard C. Breon**	Director	February 17, 2015
/s/Carol J. Burt **Carol J. Burt**	Director	February 17, 2015
/s/ Roel C. Campos **Roel C. Campos**	Director	February 17, 2015
/s/D. Robert Graham **D. Robert Graham**	Director	February 17, 2015
/s/Kevin F. Hickey **Kevin F. Hickey**	Director	February 17, 2015
/s/Christian P. Michalik **Christian P. Michalik**	Director	February 17, 2015
/s/Glenn D. Steele, Jr. **Glenn D. Steele, Jr.**	Director	February 17, 2015
/s/William L. Trubeck **William L. Trubeck**	Director	February 17, 2015
/s/ Paul E. Weaver **Paul E. Weaver**	Director	February 17, 2015

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WellCare Health Plans, Inc.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
WellCare Health Plans, Inc. and Subsidiaries
Tampa, Florida

We have audited the accompanying consolidated balance sheets of WellCare Health Plans, Inc. and subsidiaries (the "Company") as of December 31, 2014 and 2013, and the related consolidated statements of comprehensive income, changes in stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2014. Our audits also included the financial statement schedules listed in the Index at Item 15. These consolidated financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on the consolidated financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of WellCare Health Plans, Inc. and subsidiaries as of December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly in all material respects the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 16, 2015 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche, LLP

Certified Public Accountants
Tampa, Florida
February 16, 2015

WELLCARE HEALTH PLANS, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(In millions, except per share and share data)

	For the Years Ended December 31,		
	2014	2013	2012
Revenues:			
Premium	$ 12,915.5	$ 9,509.1	$ 7,400.2
Investment and other income	44.4	18.8	8.8
Total revenues	12,959.9	9,527.9	7,409.0
Expenses:			
Medical benefits	11,455.2	8,258.6	6,303.9
Selling, general and administrative	1,018.8	856.5	690.8
ACA industry fee	137.7	—	—
Medicaid premium taxes	76.5	75.7	82.2
Depreciation and amortization	59.9	44.1	31.6
Interest	39.4	11.9	4.1
Impairment and other charges	24.1	—	—
Total expenses	12,811.6	9,246.8	7,112.6
Income from operations	148.3	281.1	296.4
Bargain purchase gain	29.5	—	—
Loss on extinguishment of debt	—	(2.8)	—
Income before income taxes	177.8	278.3	296.4
Income tax expense	114.1	103.0	111.7
Net income	$ 63.7	$ 175.3	$ 184.7
Other comprehensive income, before tax:			
Change in net unrealized gains and losses on available-for-sale securities	0.5	(0.8)	1.5
Income tax expense related to other comprehensive income	(0.2)	(0.3)	0.6
Other comprehensive income, net of tax	0.7	(0.5)	0.9
Comprehensive income	$ 64.4	$ 174.8	$ 185.6
Earnings per share (see Note 5):			
Basic	$ 1.45	$ 4.03	$ 4.29
Diluted	$ 1.44	$ 3.98	$ 4.22
Weighted average common shares outstanding:			
Basic	43,864,367	43,535,927	43,104,216
Diluted	44,163,601	44,000,563	43,826,285

See notes to consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)

	December 31,	
Assets	**2014**	**2013**
Current Assets:		
Cash and cash equivalents	$ 1,313.5	$ 1,482.5
Investments	172.8	314.7
Premiums receivable, net	609.0	490.7
Pharmacy rebates receivable, net	358.9	165.5
Receivables from government partners	83.0	—
Funds receivable for the benefit of members	781.5	93.5
Income taxes receivable	—	7.1
Prepaid expenses and other current assets, net	170.5	115.0
Deferred income tax asset	37.1	23.7
Total current assets	3,526.3	2,692.7
Property, equipment and capitalized software, net	187.1	147.4
Goodwill	263.2	236.8
Other intangible assets, net	101.0	66.5
Long-term investments	257.3	80.4
Restricted investments	150.3	82.5
Deposits and other assets	9.8	144.4
Total Assets	$ 4,495.0	$ 3,450.7
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical benefits payable	$ 1,483.8	$ 953.4
Unearned premiums	86.9	0.2
Accounts payable	18.9	22.3
Other accrued expenses and liabilities	294.7	187.7
Current portion of amount payable related to investigation resolution	35.2	36.2
Income taxes payable	1.9	—
Other payables to government partners	14.3	37.3
Total current liabilities	1,935.7	1,237.1
Deferred income tax liability	48.4	55.4
Amount payable related to investigation resolution	—	34.1
Long-term debt	900.0	600.0
Other liabilities	15.0	6.2
Total Liabilities	2,899.1	1,932.8
Commitments and contingencies (see Note 13)	—	—
Stockholders' Equity:		
Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, $0.01 par value (100,000,000 authorized, 43,914,106 and 43,766,645 shares issued and outstanding at December 31, 2014 and December 31, 2013, respectively)	0.4	0.4
Paid-in capital	503.0	489.4
Retained earnings	1,093.1	1,029.4
Accumulated other comprehensive loss	(0.6)	(1.3)
Total Stockholders' Equity	1,595.9	1,517.9
Total Liabilities and Stockholders' Equity	$ 4,495.0	$ 3,450.7

See notes to consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY
(In millions, except share data)

	Common Stock					
	Shares	Amount	Paid in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Stockholders' Equity
Balance at January 1, 2012	42,848,798	$ 0.4	$ 448.8	$ 669.4	$ (1.7)	$ 1,116.9
Common stock issued for exercised stock options	243,307	—	9.4	—	—	9.4
Common stock issued for vested restricted stock and restricted stock units	128,840	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(8,570)	—	(6.5)	—	—	(6.5)
Equity-based compensation expense, net of forfeitures	—	—	14.9	—	—	14.9
Incremental tax benefit from equity-based compensation	—	—	2.8	—	—	2.8
Comprehensive income	—	—	—	184.7	0.9	185.6
Balance at December 31, 2012	43,212,375	0.4	469.4	854.1	(0.8)	1,323.1
Common stock issued for exercised stock options	390,942	—	10.3	—	—	10.3
Common stock issued for vested restricted stock and restricted stock units	231,154	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(67,826)	—	(4.1)	—	—	(4.1)
Equity-based compensation expense, net of forfeitures	—	—	12.5	—	—	12.5
Incremental tax benefit from equity-based compensation	—	—	1.3	—	—	1.3
Comprehensive income	—	—	—	175.3	(0.5)	174.8
Balance at December 31, 2013	43,766,645	0.4	489.4	1,029.4	(1.3)	1,517.9
Common stock issued for exercised stock options	20,625	—	0.5	—	—	0.5
Common stock issued for vested restricted stock units and performance stock units	178,772	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(51,936)	—	(3.1)	—	—	(3.1)
Equity-based compensation expense, net of forfeitures	—	—	15.7	—	—	15.7
Incremental tax benefit from equity-based compensation	—	—	0.5	—	—	0.5
Comprehensive income	—	—	—	63.7	0.7	64.4
Balance at December 31, 2014	43,914,106	0.4	503.0	1,093.1	(0.6)	1,595.9

See notes to consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	For the Years Ended December 31,		
	2014	2013	2012
Cash provided by (used in) operating activities:			
Net income	63.7	175.3	184.7
Adjustments to reconcile net income to net cash provided by (used in) operating activities:			
Depreciation and amortization	59.9	44.1	31.6
Equity-based compensation expense	15.7	12.5	14.9
Bargain purchase gain	(29.5)	—	—
Asset impairment and other charges	24.1	9.0	—
Loss on extinguishment of debt	—	2.8	—
Incremental tax benefit from equity-based compensation	(0.6)	(3.6)	(3.8)
Deferred taxes, net	(6.8)	15.5	18.8
Provision for doubtful receivables	15.2	10.6	16.6
Changes in operating accounts, net of effects from acquisitions:			
Premiums receivable, net	(46.2)	(77.3)	(180.3)
Pharmacy rebates receivable, net	(161.2)	(38.7)	(12.4)
Prepaid expenses and other assets, net	(31.8)	(13.7)	(29.0)
Medical benefits payable	423.4	148.8	(38.6)
Unearned premiums	82.4	0.1	—
Accounts payable and other accrued expenses	10.1	(30.8)	14.9
Other receivables/payables to government partners	(106.0)	(51.0)	(12.1)
Amount payable related to investigation resolution	(35.1)	(35.2)	(45.8)
Income taxes receivable/payable, net	9.5	9.8	7.8
Other, net	12.5	0.7	2.0
Net cash provided by (used in) operating activities	299.3	178.9	(30.7)
Cash used in investing activities:			
Acquisitions, net of cash acquired	48.0	(40.5)	(126.6)
Cash advanced for acquisitions	—	(133.6)	—
Purchases of investments	(346.7)	(416.7)	(465.6)
Proceeds from sale and maturities of investments	359.2	375.8	436.8
Purchases of restricted investments	(70.0)	(45.8)	(36.6)
Proceeds from maturities of restricted investments	8.7	32.3	30.5
Additions to property, equipment and capitalized software, net	(74.8)	(62.0)	(61.3)
Net cash used in investing activities	(75.6)	(290.5)	(222.8)
Cash (used in) provided by financing activities:			
Proceeds from debt, net of financing costs paid	298.6	816.4	(0.6)
Proceeds from exercises of stock options	0.5	10.3	9.4
Incremental tax benefit from equity-based compensation	0.6	3.6	3.8
Repurchase and retirement of shares to satisfy tax withholding requirements	(3.1)	(4.1)	(6.5)
Payments on debt	—	(365.0)	(11.3)

	For the Years Ended December 31,		
	2014	2013	2012
Payments on capital leases	(1.4)	(1.6)	(2.2)
Funds (paid) received for the benefit of members, net	(687.9)	34.0	36.3
Net cash (used in) provided by financing activities	(392.7)	493.6	28.9
(Decrease) increase in cash and cash equivalents	(169.0)	382.0	(224.6)
Balance at beginning of period	1,482.5	1,100.5	1,325.1
Balance at end of period	1,313.5	1,482.5	1,100.5
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:			
Cash paid for taxes	100.9	80.5	101.0
Cash paid for interest	36.9	6.3	3.6
SUPPLEMENTAL DISCLOSURES OF NON-CASH TRANSACTIONS:			
Non-cash additions to property, equipment, and capitalized software	11.7	2.9	3.3

See notes to consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
Years Ended December 31, 2014, 2013, and 2012
(In millions, except member, per share and share data)

1. ORGANIZATION AND BASIS OF PRESENTATION

WellCare Health Plans, Inc., (the "Company," "we," "us," or "our"), provides managed care services exclusively to government-sponsored health care programs. The Company was formed as a Delaware limited liability company in May 2002 to acquire our Florida, New York and Connecticut health plans. We completed the acquisition of the health plans through two concurrent transactions in July 2002. In July 2004, immediately prior to the closing of our initial public offering, we merged the limited liability company into a Delaware corporation and changed our name to WellCare Health Plans, Inc.

As of December 31, 2014, we served approximately 4.1 million members. In 2014, we operated Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, New Jersey, New York and South Carolina. In connection with our acquisitions of Medicaid plans in South Carolina and Missouri (see Note 3), our Medicaid operations in those states began in February 2013 and April 2013, respectively.

Our Medicaid contract in Ohio expired on June 30, 2012. We were not awarded a Medicaid contract in Ohio for the 2013 fiscal year; however, the state contracted with us to provide services to Ohio Medicaid beneficiaries through the transition period, which ended June 30, 2013. As of July 1, 2013, we no longer provided Medicaid services in Ohio. The Ohio Medicaid contract contributed approximately $137.4 million, and $265.3 million of premium revenue, net of premium taxes, to our operations for the years ended December 31, 2013 and 2012, respectively.

As of December 31, 2014, we offered Medicare Advantage ("MA") coordinated care plans ("CCPs") in certain counties in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Mississippi, Missouri, New Jersey, New York, Ohio, South Carolina, Tennessee and Texas, as well as stand-alone Medicare prescription drug plans ("PDP") in 49 states and the District of Columbia. Our MA plans in Arkansas, Mississippi, South Carolina and Tennessee are attributable to our acquisition of Windsor Health Group, Inc. ("Windsor") and our MA operations in those states began on January 1, 2014. Effective January 1, 2015, we no longer offer MA plans in the states of Arizona, Missouri and Ohio, which, combined, accounted for approximately $97.7 million, $127.7 million and $83.4 million of premium revenue, net of premium taxes, for the years ended December 31, 2014, 2013 and 2012, respectively.

Basis of Presentation and Use of Estimates

The consolidated balance sheets and statements of comprehensive income (loss), changes in stockholders' equity, and cash flows include the accounts of the Company and all of its majority-owned subsidiaries. We eliminated all intercompany accounts and transactions.

We prepared the consolidated financial statements in accordance with accounting principles generally accepted in the United States ("GAAP"), which requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We base these estimates on our knowledge of current events and anticipated future events and evaluate and update our assumptions and estimates on an ongoing basis; however, actual results may differ from our estimates. We evaluated all material events subsequent to the date of these consolidated financial statements.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Recently Adopted Accounting Standards

In July 2013, the Financial Accounting Standards Board ("FASB") issued ASU 2013-11, "*Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists.*" This update addresses the diversity in practice regarding financial statement presentation of an unrecognized tax benefit when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. The guidance requires an unrecognized tax benefit, or a portion thereof, to be presented in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. To the extent the deferred tax asset is not available at the reporting date to settle any additional income taxes that would result from the disallowance of a tax position, the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with the deferred tax asset. The amendments in this standard are effective for reporting periods beginning after December 15, 2013, with early adoption permitted. We adopted this standard effective January 1, 2014, without any material impact on our consolidated financial position, results of operations or cash flows.

In February 2013, the FASB issued ASU 2013-04, *Liabilities (Topic 405): Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation Is Fixed at the Reporting Date.* This update provides guidance for the recognition, measurement and disclosure of obligations resulting from joint and several liability arrangements for which the total amount of the obligation within the scope of the guidance is fixed at the reporting date. The guidance in this update also requires the entity to disclose the nature and amount of the obligation, as well as other information about such obligations. The guidance is effective for fiscal years beginning after December 15, 2013, with early adoption permitted. We adopted this standard effective January 1, 2014, without any material impact on our consolidated financial position, results of operations or cash flows.

In July 2011, the FASB issued ASU 2011-06, "*Other Expenses – Fees Paid to the Federal Government by Health Insurers.*" This update addresses accounting for the annual fees mandated by the ACA. The ACA imposes an annual fee on health insurers, payable to the U.S. government, calculated on net premiums and third-party administrative agreement fees. The updated standard requires that the liability for the fee be estimated and accrued in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense. The fees are initiated for calendar years beginning January 1, 2014, and the amendments provided by this update become effective for calendar years beginning after December 31, 2013. We adopted this standard effective January 1, 2014. See additional discussion in '*ACA Industry Fee*'.

Premium Revenue Recognition and Premiums Receivable

We earn premium revenue through our participation in Medicaid, Medicaid-related and Medicare programs. Our Medicaid contracts with state agencies generally are multi-year contracts subject to annual renewal provisions. Our Medicare contracts with CMS renew annually. Our Medicare and Medicaid contracts establish fixed, monthly premium rates per member ("PMPM"), which are generally determined at the beginning of each new contract renewal period; however, premiums may be adjusted by CMS and state agencies throughout the terms of the contracts in certain cases. Premium rate changes are recognized in the period the change becomes effective, when the impact of the change in the rate is reasonably estimable, and collection is assured. Our contracts also have additional provisions as described in the sections below.

We recognize premium revenue in the period in which we are obligated to provide services to our members. We are generally paid by CMS and state agencies in the month in which we provide services. On a monthly basis, we bill members for any premiums for which they are responsible according to their respective plan. We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in the consolidated balance sheets. Unearned premiums are recognized as revenue when we provide the related services. Member premiums are recognized as revenue in the period of service. We estimate, on an on-going basis, the amount of members' billings that may not be collectible, based on our evaluation of historical trends. An allowance is established for the estimated amount that may not be collectible. In addition, we routinely monitor the collectability of specific premiums receivable from CMS and state agencies, including Medicaid receivables for obstetric deliveries and newborns and net receivables for member retroactivity and reduce revenue and premiums receivable by the amount we estimate may not be collectible. We reported premiums receivable net of an allowance for uncollectible premiums receivable of $21.1 million and $15.8 million at December 31, 2014 and 2013, respectively. Historically, the provision for uncollectible premiums for member premiums receivable has not been material relative to consolidated premium revenue.

Premium payments are based upon eligibility lists produced by CMS and state agencies. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, CMS and state agencies require us to reimburse them for premiums that we received for individuals who were subsequently determined by us, or by CMS or state agencies, to be ineligible for any government-sponsored program or to belong to a plan other than ours. Additionally, the verification of membership may result in additional premiums due to us from CMS and state agencies for individuals who were subsequently determined to belong to our plan for periods in which we received no premium for those members. We estimate the amount of outstanding retroactivity adjustments and adjust premium revenue based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. We record amounts receivable in premiums receivable, net and amounts payable in other accrued expenses and liabilities in the consolidated balance sheets.

Supplemental Medicaid Premiums

We earn, or earned, supplemental premium payments for eligible obstetric deliveries and newborns of our Medicaid members in Georgia, Illinois, Kentucky, Missouri, New York, South Carolina and, until June 30, 2013, in Ohio. Each state Medicaid contract specifies how and when these supplemental payments are earned and paid. Upon delivery of a newborn, we notify the state agency according to the contract terms. We also earn supplemental Medicaid premium payments in some states for high cost drugs and certain services such as early childhood prevention screenings. We recognize supplemental premium revenue in the period we provide related services to our members. For the years ended December 31, 2014, 2013, and 2012 we

recognized approximately $278.4 million, $242.9 million and $246.3 million, respectively, of supplemental Medicaid premium revenue.

Medicaid Risk-Adjusted Premiums

In some instances, our Medicaid premiums are subject to risk score adjustments based on the health profile of our membership. Generally, the risk score is determined by the state agency's analysis of encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The frequency of when states adjust premiums varies, but is usually done quarterly or semi-annually on a retrospective basis. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured.

Medicaid ACA Industry Fee reimbursement

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA") imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers which began in 2014. As discussed in "ACA Industry Fee", we have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. Consequently, we recognized $124.6 million of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2014.

Medicare Risk-Adjusted Premiums

CMS provides risk-adjusted payments for MA Plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which is possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. Historically, we have not experienced significant differences between our estimates and amounts ultimately received. However, in the third quarter of 2013, we recognized risk adjusted premium received as part of the 2012 final settlement that was higher than our original estimates, mainly related to members in our California MA plan that were new to Medicare in 2012. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could materially reduce premium revenue in the year in which CMS determines a refund is required and could be material to our results of operations, financial position and cash flows. Premiums receivable in the accompanying condensed consolidated balance sheets include risk-adjusted premiums receivable of $178.7 million and $107.2 million as of December 31, 2014 and 2013, respectively.

Minimum Medical Expense and Risk Corridor Provisions

We may be required to refund certain premium revenue to state agencies and CMS under various contractual and plan arrangements. We estimate the impact of the following arrangements on a monthly basis and reflect any adjustments to premium revenues in current operations. We report the estimated net amounts due to state agencies and CMS in other payables to government partners in the consolidated balance sheets.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. We estimate the amounts due to the state agencies as a return of premium based on the terms of our contracts with the applicable state agency.

Our MA and PDP prescription drug plan premiums are subject to risk sharing through the CMS Medicare Part D risk corridor provisions. The risk corridor calculation compares our actual experience to the target amount of prescription drug costs, limited to costs under the standard coverage as defined by CMS, less rebates included in our submitted plan year bid. We receive additional premium from CMS if our actual experience is more than 5% above the target amount. We refund premiums

to CMS if our actual experience is more than 5% below the target amount. Based on the risk corridor provision and PDP activity-to-date, an estimated risk-sharing receivable or payable is recorded as an adjustment to premium revenue. After the close of the annual plan year, CMS performs the risk corridor calculation and any differences are settled between CMS and our plans. Historically, we have not experienced material differences between our recorded estimates and the subsequent CMS settlement amounts.

Beginning in 2014, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), requires the establishment of a minimum medical loss ratio ("MLR") for MA plans and Part D plans, requiring them to spend not less than 85% of premiums on medical benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. MLR is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions did not have a material impact to our results of operations in 2014.

A summary of other net receivables (payables) to government partners is as follows (in millions):

	As of December 31,	
	2014	2013
Liability to states under Medicaid minimum medical expense provisions	$ (14.3)	$ (21.0)
Receivable from (liability to) CMS under risk corridor provision	84.7	(16.3)
Liability to CMS under MA/PDP minimum MLR provisions of the ACA	(1.7)	—
Net receivables (payables) to government partners[1]	$ 68.7	$ (37.3)

(1) The components of net receivables (payables) to government partners are classified in the consolidated balance sheets as $83.0 million and $14.3 million in current assets and current liabilities, respectively, as of December 31, 2014, and $37.3 million in current liabilities as of December 31, 2013.

Medicare Part D Settlements

We receive certain Part D prospective subsidy payments from CMS for our MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the prospective payments and actual claims experience. The subsidy components under Part D are described below.

Low-Income Cost Sharing Subsidy (LICS)-For qualifying LIS members, CMS reimburses us for all or a portion of the LIS member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold.

Catastrophic Reinsurance Subsidy-CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy.

Coverage Gap Discount Subsidy-CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members.

Catastrophic reinsurance subsidies and the low-income cost sharing subsidies represent cost reimbursements under the Medicare Part D program. We are fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to us. Therefore, amounts received for these subsidies are not considered premium revenue, and are reported, net of the subsidy benefits paid, as Funds receivable/held for the benefit of members in the consolidated balance sheets. The receipts and payments between us and CMS are presented on a net basis as financing activity in our consolidated statements of cash flows since we are essentially administering and paying the benefit subsidies on behalf of CMS. Historically, the settlement payments between us and CMS have not been materially different from our estimates. However, the balance of funds receivable from CMS grew substantially in 2014 due to increased drug costs relative to our bid estimates.

Coverage gap discount subsidies (CGD) advance payments are recorded as Funds receivable/held for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGD, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted Prescription Drug Event data.

Funds receivable (held) for the benefit of members consisted of the following (in millions):

	As of December 31,	
	2014	2013
Low-income cost sharing subsidy	$ 323.1	$ 95.4
Catastrophic reinsurance subsidy	492.5	19.6
Coverage gap discount subsidy	(34.1)	(21.5)
Funds receivable for the benefit of members	$ 781.5	$ 93.5

Medical Benefits Expense and Medical Benefits Payable

We recognize the cost of medical benefits in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits expense includes direct medical expenses and certain medically-related administrative costs.

Direct medical expenses include amounts paid or payable to hospitals, physicians, pharmacy benefit managers and providers of ancillary services. We also record direct medical expenses for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by others. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant. We record direct medical expense for our estimates of provider settlement due to clarification of contract terms, out-of-network reimbursement, claims payment differences and amounts due to contracted providers under risk-sharing arrangements. We estimate pharmacy rebates earned based on historical utilization of specific pharmaceuticals, current utilization and contract terms and record amounts as a reduction of recorded direct medical expenses.

Consistent with the criteria specified and defined in guidance issued by the Department of Health and Human Services ("HHS") for costs that qualify to be reported as medical benefits under the minimum medical loss ratio provision of the ACA, we record certain medically-related administrative costs such as preventive health and wellness, care management, and other quality improvement costs, as medical benefits expense. All other medically-related administrative costs, such as utilization review services, network and provider credentialing and claims handling costs, are recorded in selling, general, and administrative expense.

Medical benefits payable represents amounts for claims fully adjudicated but not yet paid and estimates for IBNR. Our estimate of IBNR is the most significant estimate included in our consolidated financial statements. We determine our best estimate of the base liability for IBNR utilizing consistent standard actuarial methodologies based upon key assumptions which vary by business segment. Our assumptions include current payment experience, trend factors, and completion factors. Trend factors in our standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

After determining an estimate of the base liability for IBNR, we make an additional estimate, also using standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than the estimated base reserve. We refer to this additional liability as the provision for moderately adverse conditions. Our estimate of the provision for moderately adverse conditions captures the potential adverse development from factors such as:

- our entry into new geographical markets;
- our provision of services to new populations such as the aged, blind and disabled;
- variations in utilization of benefits and increasing medical costs, including higher drug costs;
- changes in provider reimbursement arrangements;
- variations in claims processing speed and patterns, claims payment and the severity of claims; and
- health epidemics or outbreaks of disease such as the flu or enterovirus.

We consider the base actuarial model liability and the provision for moderately adverse conditions as part of our overall assessment of our IBNR estimate to properly reflect the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states. We evaluate our estimates of medical benefits payable as we obtain more complete claims information and medical expense trend data over time. We record differences between actual experience and estimates used to establish the liability, which we refer to as favorable and

unfavorable prior period developments, as increases or decreases to medical benefits expense in the period we identify the differences. The cumulative effect of prior year reserve development in 2014 and 2013 was an unfavorable $48.1 million and a favorable $3.0 million; respectively, however, we recognized unfavorable prior period reserve development in three of four quarters in 2013, and in the first and second quarters of 2014. Based on the unfavorable prior period reserve development experience in these quarters, we have refined certain of these assumptions, resulting in increased current period medical benefits costs incurred in 2014.

Reinsurance

We enter into excess of loss reinsurance arrangements to reduce the risk associated with large losses or catastrophic events. We are contingently liable in the event the reinsurance companies do not meet their contractual obligations. We evaluate the financial condition of the reinsurance companies on a regular basis and only contract with well-known, well-established reinsurance companies that have strong financial ratings. We evaluate the terms of the arrangements to determine whether risk transfer and other criteria are met to qualify as reinsurance contracts for GAAP accounting purposes in accordance with ASC 944, Financial Services-Insurance. Premiums paid, or ceded, to the reinsurer, are recorded as a reduction to premium revenue, and expected reimbursements for losses, or recoveries, are recorded as a reduction to medical benefits expense. Amounts recoverable from the reinsurer are estimated in a manner consistent with the claim liability associated with the reinsured policies.

ACA Industry Fee

The total ACA industry fee levied on the health insurance industry was $8 billion in 2014 and will be $11.3 billion in 2015, with increasing annual amounts thereafter, growing to $14.3 billion by 2018. After 2018, the industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S. health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. The initial estimated liability for each year is accrued as of January 1, with a corresponding deferred expense asset that is amortized over 12 months to expense on a straight line basis. The fee is payable by September 30 of each year. We incurred $137.7 million of such fees in 2014. We have received amendments, written agreements or other documentation from all our Medicaid state customers, that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes for 2014. See discussion under "Premium Revenue Recognition and Premiums Receivable".

Equity-Based Employee Compensation

During the second quarter of 2013, our stockholders approved the WellCare Health Plans, Inc. 2013 Incentive Compensation Plan (the "2013 Plan"). Upon approval of the 2013 Plan, a total of 2,500,000 shares of our common stock were available for issuance pursuant to the 2013 Plan, minus any shares subject to outstanding awards granted on or after January 1, 2013 under our 2004 Equity Incentive Plan ("the Prior Plan"). In addition, shares subject to awards forfeited under the Prior Plan will become available for issuance under the 2013 Plan. No further awards are permitted to be granted under our Prior Plan. The Compensation Committee of our Board of Directors (the "Compensation Committee") awards certain equity-based compensation under our stock plans, including stock options, restricted stock units ("RSUs"), performance stock units ("PSUs") and market stock units ("MSUs"), each of which is described below:

RSUs - For each RSU granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. RSUs typically vest one to three years from the date of grant.

PSUs - The actual number of common stock shares earned upon vesting will range from zero shares up to 100%, 150% or 200% of the target award, depending on the award date, the target award amounts for the PSU awards and our achievement of certain financial and quality-based performance goals set by the Compensation Committee at its sole discretion. PSUs generally cliff-vest 3 years from the grant date based on the achievement of the performance goals and conditioned on the employee's continued service through the vesting date.

MSUs - The number of shares of common stock earned upon vesting is determined based on the ratio of the Company's average common stock price during the last 30 days market trading days of the calendar year immediately preceding the vesting date to the comparable average common stock price in the year immediately preceding the grant date, applied to the base units granted. The performance ratio is capped at 150% or 200%, depending on the grant date. If our common stock price declines by more than 50% over the performance period, no shares are earned by the recipient. Each vested MSU represents one share of common stock and will be paid in shares of common stock, net of taxes.

We estimate equity-based compensation expense based on awards ultimately expected to vest. We make assumptions of forfeiture rates at the time of grant and continuously reassess our assumptions based on actual forfeiture experience. We estimate compensation cost for stock options, RSUs and MSUs based on the grant date fair value and recognize the expense ratably over the vesting period of the award. For stock options, the grant date fair value is measured using the Black-Scholes options-pricing model. For RSUs, the grant date fair value is based on the closing price of our common stock on the date of grant. For MSUs, the grant date fair value is measured using a Monte Carlo simulation approach which estimates the fair value of awards based on randomly generated simulated stock-price paths through a lattice-type structure. MSUs expected to vest are recognized as expense on a straight-line basis over the vesting period, which is generally three years.

Our PSUs are subject to variable accounting since they do not have a grant date fair value for accounting purposes due to the subjective nature of the terms of the PSUs which precludes a mutual understanding of the key terms and conditions. We recognize expense for PSUs ultimately expected to vest over the requisite service period based our estimates of progress made towards the achievement of the predetermined performance measures and changes in the market price of our common stock.

Member Acquisition Costs

We incur member acquisition costs, including internal commissions, external agent commissions on renewal policies, agent referral commissions, policy issuance and other administrative costs, in the acquisition and retention of our members. We record these costs as selling, general and administrative expense in the period we incur them.

We advance commissions to external agents and brokers for the acquisition of new members to our MA and PDP plans and defer amortization of these costs to the period in which we earn associated premium revenue, which is generally not more than one year.

Advertising Costs

We record the production costs of advertising activities as selling, general and administrative expense when incurred. We expense the costs of advertising campaigns in the period the advertising takes place. We recorded advertising and related marketing expense of $5.4 million, $3.2 million, and $7.2 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Medicaid Premium Taxes

Premiums related to our Medicaid contracts with Georgia, Hawaii, New Jersey and New York, and, until June 30, 2013, Ohio, are, or were, subject to an assessment or tax on Medicaid premiums. The premium revenues we receive from these states include the premium tax assessment. We have reported premium taxes on a gross basis, as premium revenue and as premium tax expense in the consolidated statements of income. We recognize the premium tax assessment as expense in the period we earn the related premium revenue and remit the taxes back to the state agencies on a periodic basis. We incurred Medicaid premium taxes of $76.5 million, $75.7 million and $82.2 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Income Tax Expense (Benefit)

We record income tax expense (benefit) as incurred based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. We recognize deferred tax assets and liabilities for the estimated future tax consequences of differences between the carrying amounts of existing assets and liabilities and their respective tax basis. We measure deferred tax assets and liabilities using tax rates applicable to taxable income in the years in which we expect to recover or settle those temporary differences. We record a valuation allowance on deferred taxes if we determine it is more likely than not that we will not fully realize the future benefit of deferred tax assets. We file tax returns after the close of our fiscal year end and adjust our estimated tax receivable or liability to the actual tax receivable or due per the filed state and federal tax returns. Historically, we have not experienced significant differences between our estimates of income tax expense (benefit) and actual amounts incurred.

State and federal taxing authorities may challenge the positions we take on our filed tax returns. We evaluate our tax positions and only recognize a tax benefit if it is more likely than not that a tax audit will sustain our conclusion. Based on our evaluation of tax positions, we believe that potential tax exposures have been recorded appropriately. State and federal taxing authorities may propose additional tax assessments based on periodic audits of our tax returns. We believe our tax positions comply with applicable tax law in all material aspects and we will vigorously defend our positions on audit. The ultimate resolution of these audits may materially impact our financial position, results of operations or cash flows. We have not experienced material adjustments to our consolidated financial statements as a result of these audits.

We participate in the Internal Revenue Service ("IRS") Compliance Assurance Program ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty by working with the IRS to ensure tax return accuracy prior to filing, thereby reducing or eliminating the need for post-filing examinations.

Cash and Cash Equivalents

We classify unrestricted cash and short-term investments with original maturities of three months or less as cash and cash equivalents in the consolidated balance sheets. We record cash and cash equivalents at cost, which approximates fair value.

Investments

We classify our fixed maturity securities, including short-term, long-term, and restricted investments, as available-for-sale and report them at fair value. We record unrealized gains and losses on securities, net of deferred income taxes, as a separate component of accumulated other comprehensive loss in the consolidated balance sheets. We record investment income when earned and classify investment income earned but not received in prepaid expenses and other current assets in the consolidated balance sheets. We may purchase fixed maturity securities at a premium or discount. We amortize these premiums and discounts as adjustments to investment income over the estimated remaining term of the securities. We determine realized gains and losses on sales of securities on a specific identification basis.

We determine the fair value of fixed maturity securities based on quoted prices in active markets or market prices provided by a third-party pricing service. The third-party pricing service determines market prices using inputs such as reported trades, benchmark yields, issuer spreads, bids, offers, estimated cash flows and prepayment spreads. Based on the typical trading volumes and the lack of quoted market prices for fixed maturities, third party pricing services will normally derive the security prices through recent reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. If there are no recent reported trades, the pricing services may use matrix or model processes to develop a security price using future cash flow expectations based upon collateral performance and discount this at an estimated market rate. Our long-term investments include municipal note investments with an auction reset feature ("auction-rate securities"). We record the fair value of these auction-rate securities based on a discounted cash flow analysis.

We regularly compare the fair value of our investments to amortized cost of those investments. The evaluation of impairment is a quantitative and qualitative process which is subject to risk and uncertainties. Our fixed maturity investments are exposed to four primary sources of investment risk: credit, interest rate, liquidity and market valuation. The financial statement risks are those associated with the recognition of impairments and income, as well as the determination of fair values.

We perform a case-by-case evaluation of the underlying reasons for the decline in fair value and consider a wide range of factors about the security issuer, including assumptions and estimates about the operations of the issuer and its future earnings potential. We use our best judgment in evaluating the cause of the decline in the estimated fair value of the security and in assessing the prospects for near-term recovery. Our evaluation of impairment includes, but is not limited to:

- the length of time and the extent to which the market value has been below cost;
- the potential for impairments of securities when the issuer is experiencing significant financial difficulties;
- the potential for impairments in an entire industry sector or sub-sector;
- the potential for impairments in certain economically depressed geographic locations;
- the potential for impairments of securities where the issuer, series of issuers or industry has suffered a catastrophic type of loss or has exhausted natural resources;
- unfavorable changes in forecasted cash flows on asset-backed securities; and
- other subjective factors, including concentrations and information obtained from regulators and rating agencies.

We recognize impairments of securities when we consider a decline in fair value below the amortized cost basis to be other-than-temporary. If we intend to sell a security, or it is more likely than not that we will be required to sell the security before recovery of its amortized cost basis, we recognize an other-than-temporary impairment ("OTTI") in earnings equal to the entire difference between the security's amortized cost basis and its fair value. If we do not intend to sell the security and it is more likely than not that we will not be required to sell the security before recovery of its amortized cost basis, but the present value of the cash flows expected to be collected is less than the amortized cost basis of the security (referred to as the credit loss), we conclude an OTTI has occurred. In this instance, we bifurcate the total OTTI into the amount related to the credit loss, which we recognize in earnings as investment income, net, with the remaining amount of the total OTTI attributed to other factors (referred to as the noncredit portion) recognized as a separate component in other comprehensive income. After the recognition of an OTTI, we account for the security as if it had been purchased on the measurement date of the OTTI, with an amortized cost basis equal to the previous amortized cost basis less than the OTTI recognized in earnings. We did not realize any OTTI for the years ended December 31, 2014, 2013 or 2012.

Restricted Investments

As a condition for licensure, we are required to maintain certain funds on deposit or pledged to various state agencies. Certain of our state contracts require the issuance of surety bonds. We record our restricted investments, which include cash, cash equivalents, and other short-term investments, at fair value. We classify restricted investments as long-term regardless of the contractual maturity date of the securities held, due to the nature of the states' requirements.

Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets, net, are comprised of the following (in millions):

	As of December 31,	
	2014	2013
Prepaid expenses	$ 46.5	$ 58.4
Pharmaceutical coverage gap discounts receivable	52.8	13.5
Advances to providers	5.5	6.8
Other	67.0	37.6
	171.8	116.3
Allowance for uncollectible advances to providers	(1.3)	(1.3)
Prepaid expenses and other current assets, net	$ 170.5	$ 115.0

We record pharmaceutical coverage gap discounts receivable for amounts billed to pharmaceutical manufacturers by CMS for Medicare Part D coverage gap discounts advanced by us. Pharmaceutical manufacturers remit payments directly to us (see "Premium Revenue Recognition and Premiums Receivable - *Medicare Part D Settlements*").

Property, Equipment and Capitalized Software, net

Property, equipment and capitalized software are stated at historical cost, net of accumulated depreciation. We capitalize certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. We expense other software development costs, such as training and data conversion costs, as incurred. We capitalize the costs of improvements that extend the useful lives of the related assets.

We record depreciation expense using the straight-line method over the estimated useful lives of the related assets, which ranges from three to ten years for leasehold improvements, five for furniture and equipment, and three to five years for computer equipment and software. We include amortization of equipment under capital leases in depreciation expense. We record maintenance and repair costs as selling, general and administrative expense when incurred.

On an ongoing basis, we review events or changes in circumstances that may indicate that the carrying value of an asset may not be recoverable. If the carrying value of an asset exceeds the sum of estimated undiscounted future cash flows, we recognize an impairment loss in the current period for the difference between estimated fair value and carrying value. If assets are determined to be recoverable but the useful lives are shorter than we originally estimated, we depreciate the remaining net book value of the asset over the newly determined remaining useful lives. During 2013, we determined that we would be discontinuing certain projects going forward and, as a result, the software and development costs acquired to support these projects would not be fully recoverable. In accordance with the guidance for the impairment of long-lived assets, we evaluated these assets for recovery and recorded a pre-tax asset impairment charge of $9.0 million, which is included in selling, general and administrative expenses in our consolidated statement of comprehensive income for the year ended December 31, 2013.

Goodwill and Intangible Assets

Goodwill represents the excess of the cost over the fair market value of net assets acquired. Goodwill recorded at December 31, 2014 was $263.2 million, which consisted of $152.8 million and $110.4 million attributable to our Medicaid and Medicare Health Plans reporting segments, respectively. Goodwill recorded at December 31, 2013 was $236.8 million, which consisted of $126.8 million and $110.0 million attributable to our Medicaid and Medicare Health Plans reporting segments, respectively.

We test goodwill for impairment at the reporting unit level at least annually, or more frequently if events or circumstances indicate that it would be more likely than not that the fair value of a reporting unit is below its carrying value. Such events or circumstances could include a significant adverse change in business climate, an adverse action or assessment by a regulator, unanticipated competition and the testing for recoverability of a significant asset group within a reporting unit, among others. To determine whether goodwill is impaired, we compare an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds the estimated fair value, we compare the implied fair value of the applicable goodwill to its carrying value to measure the amount of goodwill impairment, if any. We perform our annual goodwill impairment test based on our financial position and results of operations as of June 30 of each year, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting and planning process. The annual impairment tests are based on an evaluation of estimated future discounted cash flows. The estimated discounted cash flows are based on the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense. Based on the results of our annual impairment testing in 2014, we determined that the fair value of each reporting unit substantially exceeded its carrying value and no goodwill impairment losses were recognized.

Other intangible assets resulting from our acquisitions include provider networks, broker networks, trademarks, state contracts, non-compete agreements, licenses and permits. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. These assets are allocated to reporting segments for impairment testing purposes. We review our other intangible assets for impairment when events or changes in circumstances occur, which may potentially affect the estimated useful life or recoverability of the remaining balances of our intangible assets. Such events and changes in circumstances would include significant changes in membership, state funding, federal and state government contracts and provider networks. Upon such an occurrence, recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to current forecasts of undiscounted future net cash flows expected to be generated by the assets. Identifiable cash flows are measured at the lowest level for which they are largely independent of the cash flows of other groups of assets and liabilities. If these assets are determined to be impaired, the amount of impairment recognized is measured by the amount by which the carrying amount of the assets exceeds their fair value.

During 2014, we recognized approximately $24.1 million in impairment and other charges, approximately $18.0 million of which related to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice Health Plan, Inc. ("Easy Choice"). During the year, our Easy Choice MA health plan continued to underperform, mainly reflecting an inability to improve the medical cost structure to the degree that was previously estimated, and the inability to achieve certain administrative cost savings. As a result, we performed an updated assessment of the recoverability of these intangible assets. The projections of undiscounted future net cash flows expected to be generated by the Easy Choice health plan reflected a significant decline in the anticipated long-term profitability of this business relative to projections we completed in prior periods. The decline in projected profitability resulted from the factors noted above, as well the continuing margin compression that is impacting the MA business as a whole. We compared the carrying values of the underlying intangible assets to the projected, undiscounted future net cash flows and determined that the undiscounted future net cash flows were insufficient to recover the carrying value of the assets. We measured the fair values of these assets at June 30, 2014 using an income-based valuation approach, and decreased the carrying values of the intangible assets to the estimated fair values, which resulted in an impairment charge of approximately $18.0 million. We believe the assumptions used in the income approach, including the projected cash flows associated with the assets, as well as other key factors and assumptions, including the selection of an appropriate discount rate, were consistent with those that likely market place participants would experience when operating in the same market, with the same membership. The remaining charges also include a charge for the full impairment of intangible assets associated the purchase of our Arizona MA plan after we concluded during 2014 to exit the Arizona MA market in 2015, and charges resulting from the resolution of certain matters related to the purchase price of our 2013 acquisitions. We were no longer able to recognize the latter charges as adjustments to acquired assets, since we were beyond the measurement period established in the accounting rules for business combinations.

Acquisitions

In January 2014, we acquired all of the outstanding stock of Windsor from Munich Health North America, Inc., a part of Munich Re Group. Through its subsidiaries, Windsor serves Medicare beneficiaries with MA, PDP and Medicare Supplement products. As of December 31, 2014, Windsor offered MA plans to 37,000 members in 192 counties in the states of Arkansas,

Mississippi, South Carolina and Tennessee. In addition, one of Windsor's subsidiaries offers Medicare Supplement insurance policies through which it serves approximately 43,000 members in 39 states as of December 31, 2014. Windsor also offers PDPs in 11 of the 34 CMS regions to 103,000 members as of December 31, 2014.

Effective January 1, 2014, we began offering Medicaid managed care in Essex, Hudson, Middlesex, Passaic and Union counties in New Jersey. In addition, effective July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst Health Plan of New Jersey, Inc. ("Healthfirst NJ"), which primarily relate to approximately 42,000 Healthfirst NJ Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as certain provider agreements. As a result, effective July 1, 2014, we offer Medicaid managed care in 10 counties in New Jersey.

Pro Forma Financial Information

The results of operations and financial condition for our 2012, 2013 and 2014 acquisitions have been included in our consolidated financial statements since the respective acquisition dates. The unaudited pro forma financial information presented below assumes that the acquisitions occurred as of January 1, 2012. The pro forma adjustments include the pro forma effect of the amortization of finite-lived intangible assets arising from the purchase price allocations, adjustments necessary to align the acquired companies' accounting policies to our accounting policies and the associated income tax effects of the pro forma adjustments. The following unaudited pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the acquisitions been consummated at the beginning of the periods presented. Only pro forma results for 2012 and 2013 have been presented, as Windsor was acquired on January 1, 2014, and its results of operations have been included in our consolidated financial statements from that date.

	Pro forma- unaudited	
	For the Years Ended December 31,	
(in millions, except per share data)	2013	2012
Premium revenues	$ 10,657.1	$ 9,387.9
Net earnings	$ 201.5	$ 106.4
Earnings per share:		
Basic	$ 4.63	$ 2.47
Diluted	$ 4.58	$ 2.43

3. ACQUISITIONS

Healthfirst NJ

On July 1, 2014, our New Jersey subsidiary completed the acquisition of Medicaid assets from Healthfirst NJ. The acquired assets primarily relate to approximately 42,000 Healthfirst NJ Medicaid members who were transferred to our Medicaid plan in New Jersey, as well as certain provider agreements.

Based on the preliminary purchase price allocation, we allocated $10.8 million of the purchase price to identified intangible assets and recorded the excess of purchase price over the aggregate fair values of $16.2 million as goodwill. The recorded goodwill and other intangible assets related to the Healthfirst NJ acquisition are deductible for income tax purposes. It is possible that further adjustments could be made to the purchase price and allocations depending on the resolution of certain matters related to the purchase price, although we are unable to estimate the impact at this time.

Windsor

On January 1, 2014, we acquired all of the outstanding stock of Windsor from Munich Health North America, Inc., a part of Munich Re Group. Through its subsidiaries, Windsor serves Medicare beneficiaries with MA, PDP and Medicare Supplement products. As of December 31, 2014, Windsor offered MA plans in 192 counties in the states of Arkansas, Mississippi, South Carolina and Tennessee, through which it served 37,000 members. In addition, one of Windsor's subsidiaries offers Medicare Supplement insurance policies through which it served 43,000 members in 39 states as of December 31, 2014. Windsor also offers PDPs in 11 of the 34 CMS regions, through which it served approximately 103,000 beneficiaries as of December 31, 2014. We included the results of Windsor's operations from the date of acquisition in our consolidated financial statements. Windsor's operations contributed premium revenue of $620.5 million and a net pre-tax loss of $0.3 million, including certain one-time costs for severance and integration, for the year ended December 31, 2014.

As of December 31, 2014, we have completed the accounting for the Windsor acquisition. The following table summarizes the allocation of the purchase price to the tangible and intangible assets acquired and liabilities assumed at the acquisition date.

Cash and cash equivalents	$	169.0
Investments		47.1
Premiums receivable, net		87.4
Pharmacy rebates receivable, net		32.2
Other intangible assets		54.3
Other assets		34.0
Deferred tax asset		33.6
Total assets acquired		457.6
Medical benefits payable		(107.0)
Accrued expenses and other payables		(80.8)
Deferred tax liability		(20.2)
Total liabilities assumed		(208.0)
Fair value of net assets acquired	$	249.6

As a result of the Windsor acquisition, the fair value of the net tangible and intangible assets that we acquired exceeded the total consideration payable to the seller by approximately $29.5 million. When assessing this result from an accounting perspective, we considered:

- the seller's decision to divest Windsor following a review of its business strategy in the U.S. and focus on other types of health businesses;
- the value of net assets we acquired included the benefit of net operating losses and other tax benefits, and
- a credit reflected in the purchase price for certain transition costs we expected to incur after the transaction closed.

After consideration of all relevant factors, including those cited above, and verifying that all assets acquired and liabilities assumed were identified, we concluded that the excess fair value of $29.5 million constituted a bargain purchase gain in accordance with accounting rules related to business combinations.

As reflected in the table above, we recorded $54.3 million for the preliminary valuation of identified other intangible assets, including MA and Medicare Supplement membership bases of $20.1 million (15-year useful life), PDP membership bases of $17.5 million (8-year useful life), provider networks of $5.2 million (15-year useful life), broker networks of $3.3 million (10-year useful life) and aggregated other identified intangible assets of $8.2 million (9-year useful life). We valued the other intangible assets using a combination of income and cost approaches, where appropriate. Membership bases were valued based on the income approach using a discounted future cash flow analysis based on our consideration of historical financial results and expected industry and market trends. We discounted the future cash flows by a weighted-average cost of capital based on an analysis of the cost of capital for guideline companies within our industry. We amortize the intangible assets on a straight-line basis over the period we expect these assets to contribute directly or indirectly to the future cash flows. The weighted average amortization period for these intangibles was 11.5 years.

WellCare of South Carolina

On January 31, 2013, we acquired all outstanding stock of WellCare of South Carolina, Inc. ("WCSC"), formerly UnitedHealthcare of South Carolina, Inc., a South Carolina Medicaid subsidiary of UnitedHealth Group Incorporated. We included the results of WCSC's operations from the date of acquisition in our consolidated financial statements.

We completed certain aspects of the accounting for the WCSC acquisition during the first quarter of 2014, and based on the final purchase price allocation, we allocated $24.7 million of the purchase price to identified tangible net assets and $9.5 million of the purchase price to identified intangible assets. We recorded the excess of purchase price over the aggregate fair values of $12.7 million as goodwill. The recorded goodwill and other intangible assets related to the WCSC acquisition are deductible for tax purposes.

Missouri Care

On March 31, 2013, we acquired all outstanding stock of Missouri Care, Incorporated, a subsidiary of Aetna Inc. ("Missouri Care"), which participates in the Missouri HealthNet Medicaid program. We began serving Missouri Care members effective April 1, 2013 and we included the results of Missouri Care's operations from the date of acquisition in our consolidated financial statements.

We completed certain aspects of the accounting for the Missouri Care acquisition during the first quarter of 2014, and based on the final purchase price allocation, we allocated $10.2 million of the purchase price to identified tangible net assets and $7.1 million of the purchase price to identified intangible assets. We recorded the excess of purchase price over the aggregate fair values of $10.7 million as goodwill, which reflects a $7.7 million increase recognized during the first quarter of 2014. The recorded goodwill and other intangible assets related to the Missouri Care acquisition are deductible for income tax purposes.

Easy Choice

On November 9, 2012, we acquired all outstanding interests in America's 1st Choice California Holdings, LLC, the sole shareholder of Easy Choice Health Plan, Inc. (collectively, "Easy Choice"). We included the results of Easy Choice's operations from the date of acquisition in our consolidated financial statements.

We completed certain aspects of the accounting for the Easy Choice acquisition during 2013, and based on the final purchase price allocation, we allocated $7.6 million of the purchase price to identified tangible net liabilities and $47.7 million of the purchase price to identified intangible assets. We recorded $110.0 million of goodwill for the excess of the purchase price over the estimated fair value of net assets and identifiable intangible assets acquired and assigned the goodwill to our Medicare Health Plans segment. Recorded goodwill and other intangible assets related to the Easy Choice acquisition are not deductible for tax purposes.

4. SEGMENT REPORTING

On a regular basis, we evaluate discrete financial information and assess the performance of our three reportable segments, Medicaid Health Plans, Medicare Health Plans and Medicare PDPs, to determine the most appropriate use and allocation of Company resources. Prior to the Windsor acquisition on January 1, 2014, we identified three operating segments for our company: Medicaid, MA and PDP. In conjunction with the Windsor acquisition, we began offering Medicare Supplement products and we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of Medicare Supplement and MA operations acquired as part of the Windsor acquisition together with our legacy MA plans. Accordingly, we include results for Medicare Supplement operations together with MA and renamed the segment as Medicare Health Plans. Similarly, we include the PDP operations acquired as part of the Windsor acquisition together with WellCare's PDPs and renamed the segment as Medicare PDPs. In addition, we renamed the Medicaid segment Medicaid Health Plans; however, there were no changes to the composition of this segment.

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and other state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Program ("CHIP") and Managed Long-Term Care ("MLTC") programs. TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP programs provide assistance to qualifying families who are not eligible for Medicaid because their income exceeds the applicable income thresholds. The MLTC program is designed to help people with chronic illnesses or who have disabilities and need health and long-term care services, such as home care or adult day care, to enable them to stay in their homes and communities as long as possible.

Our Medicaid operations in certain states individually account for 10% or more of our consolidated premium revenue. Those states, and the respective Medicaid premium revenue as a percentage of total consolidated premium revenue, are as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Kentucky	18%	14%	10%
Florida	14%	12%	13%
Georgia	13%	16%	20%

In February 2014, we executed a contract with the Florida Agency for Health Care Administration ("AHCA") pursuant to which our Staywell health plan participates in eight out of the state's 11 regions in the new program, which was fully implemented as of August 2014. Our 2012-2015 Florida Medicaid contracts were terminated early in connection with the implementation of the new program.

The Georgia Department of Community Health (the "Georgia DCH") exercised its option in June 2014 to extend the term of our Georgia Medicaid contract until June 30, 2015. There is one remaining one-year option term, exercisable by the Georgia DCH, which would potentially extend the contract term to June 30, 2016. On February 9, 2015, the Georgia Department of Community Health issued a request for proposals for its Medicaid program, under which services would commence on July 1, 2016. We are currently preparing our response. A total of nine companies, including us, have been deemed qualified to bid.

Our primary Kentucky contract commenced in July 2011, has an initial three-year term and provides for four additional one-year option terms, exercisable upon mutual agreement of the parties, which potentially extends the total term until July 2018. The parties have exercised the first option term.

Medicare Health Plans

Our Medicare Health Plans reportable segment includes the combined operations of both the MA and Medicare Supplement operating segments. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical and prescription drug benefits. MA is Medicare's managed care alternative to the original Medicare program, which provides individuals standard Medicare benefits directly through CMS. Our MA CCPs generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer coverage of prescription drug benefits under the Medicare Part D program as a component of most of our MA plans. We also offer Medicare Supplement policies in certain states.

Medicare PDPs

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our Medicare PDPs segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the participating drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dually-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Summary of Financial Information

We allocate goodwill and other intangible assets to our reportable operating segments. We do not allocate any other assets and liabilities, investment and other income, or selling, general and administrative, depreciation and amortization, or interest expense to our reportable operating segments, with the exception of the ACA industry fee. The Company's decision-makers primarily use premium revenue, medical benefits expense and gross margin to evaluate the performance of our reportable operating segments. A summary of financial information for our reportable operating segments through the gross margin level and a reconciliation to income before income taxes is presented in the tables below.

	For the Years Ended December 31,		
	2014	2013	2012
Premium revenue:			
Medicaid Health Plans	$ 7,773.9	$ 5,661.2	$ 4,471.2
Medicare Health Plans	**3,963.2**	**3,071.0**	**1,936.4**
Medicare PDPs	1,178.4	776.9	992.6
Total premium revenue	12,915.5	9,509.1	7,400.2
Medical benefits expense:			
Medicaid Health Plans	**6,853.1**	**4,927.4**	**3,892.0**
Medicare Health Plans	3,506.9	2,659.5	1,630.6
Medicare PDPs	**1,095.2**	**671.7**	**781.3**
Total medical benefits expense	11,455.2	8,258.6	6,303.9
ACA industry fee expense:			
Medicaid Health Plans	81.6	—	—
Medicare Health Plans	**44.7**	—	—
Medicare PDPs	11.4	—	—
Total ACA industry fee expense	137.7	—	—
Gross margin:			
Medicaid Health Plans	**839.2**	733.8	**579.2**
Medicare Health Plans	411.6	411.5	305.8
Medicare PDPs	**71.8**	105.2	**211.3**
Total gross margin	1,322.6	1,250.5	1,096.3
Investment and other income	**44.4**	**18.8**	**8.8**
Other expenses	(1,218.7)	(988.2)	(808.7)
Income from operations	**$ 148.3**	**$ 281.1**	**$ 296.4**

5. EARNINGS PER SHARE

We compute basic net income per common share on the basis of the weighted-average number of unrestricted common shares outstanding. We compute diluted net income per common share on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted stock, RSUs, MSUs and PSUs using the treasury stock method.

We calculated weighted-average common shares outstanding — diluted as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Weighted-average common shares outstanding — basic	43,864,367	43,535,927	43,104,216
Dilutive effect of:			
Unvested restricted stock units, market stock units and performance stock units	290,392	342,346	526,030
Stock options	8,842	122,290	196,039
Weighted-average common shares outstanding — diluted	44,163,601	44,000,563	43,826,285
Anti-dilutive stock options, restricted stock awards and performance equity awards excluded from computation	30,217	79,978	57,455

6. INVESTMENTS

The Company considers all of its investments as available-for-sale securities. The amortized cost, gross unrealized gains or losses and estimated fair value of short-term and long-term investments by security type are summarized in the following tables.

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
December 31, 2014				
Auction rate securities	$ 34.1	$ —	$ (1.8)	$ 32.3
Certificates of deposit	0.3	—	—	0.3
Corporate debt and other securities	162.2	0.1	(0.4)	161.9
Money market funds	41.4	—	—	41.4
Municipal securities	86.9	0.5	(0.1)	87.3
Variable rate bond fund	85.1	0.2	(0.1)	85.2
U.S. government securities	21.7	0.1	(0.1)	21.7
Total	$ 431.7	$ 0.9	$ (2.5)	$ 430.1
December 31, 2013				
Auction rate securities	$ 34.2	$ —	$ (2.4)	$ 31.8
Certificates of deposit	1.6	—	—	1.6
Corporate debt and other securities	104.5	0.1	(0.1)	104.5
Money market funds	43.4	—	—	43.4
Municipal securities	108.9	—	—	108.9
Variable rate bond fund	84.9	0.4	—	85.3
U.S. government securities	19.5	0.1	—	19.6
Total	$ 397.0	$ 0.6	$ (2.5)	$ 395.1

Contractual maturities of long-term available-for-sale investments at December 31, 2014 are as follows:

	Total	Within 1 Year	1 Through 5 Years	5 Through 10 Years	Thereafter
Auction rate securities	$ 32.3	$ —	$ —	$ —	$ 32.3
Certificates of deposit	0.3	0.3	—	—	—
Corporate debt and other securities	161.9	23.2	137.4	0.4	0.9
Money market funds	41.4	41.4	—	—	—
Municipal securities	87.3	19.3	57.8	8.7	1.5
Variable rate bond fund	85.2	85.2	—	—	—
U.S. government securities	21.7	3.4	18.2	—	0.1
Total	$ 430.1	$ 172.8	$ 213.4	$ 9.1	$ 34.8

Actual maturities may differ from contractual maturities due to the exercise of pre-payment options.

Excluding investments in U.S. government securities, we are not exposed to any significant concentration of credit risk in our fixed maturities portfolio. Our long-term investments include $32.3 million estimated fair value of municipal note securities with an auction reset feature ("auction rate securities"), which were issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven or 35 days. We consider our auction rate securities to be in an inactive market as auctions continued to fail in 2014. Our auction rate securities have been in an unrealized loss position for more than twelve months. Two auction rate securities with an aggregate par value of $22.5 million have investment grade security credit ratings and one auction rate security with a par value of $11.6 million has a credit rating below investment grade. Our auction rate securities are covered by government guarantees or municipal bond insurance and we have the ability and intent to hold these

securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and have not recorded any other-than-temporary impairment as of December 31, 2014.

Redemptions and sales of our auction rate securities during the years ended December 31, 2014 and 2013 were not material, however, during the year ended December 31, 2012, we redeemed $0.8 million of auction rate securities at par. We did not realize any losses associated with selling or redeeming our auction rate securities for those years.

During the years ended December 31, 2014, 2013, and 2012, respectively, we sold or redeemed fixed maturity bond investments totaling $348.7 million, $360.2 million, $378.1 million, respectively. Realized gains and losses on sales and redemptions of investments, including sales and redemptions of the fixed maturity bond investments, were not material for the years ended December 31, 2014, 2013 or 2012. Additionally, we did not realize any OTTI for any of these years.

7. RESTRICTED INVESTMENTS

The amortized cost, gross unrealized gains, gross unrealized losses and fair value of our restricted cash and investment securities are as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
December 31, 2014				
Cash	$ 53.3	$ —	$ —	$ 53.3
Certificates of deposit	1.0	—	—	1.0
Money market funds	65.9	—	—	65.9
U.S. government securities	30.1	0.1	(0.1)	30.1
Total	$ 150.3	$ 0.1	$ (0.1)	$ 150.3
December 31, 2013				
Cash	$ 40.2	$ —	$ —	$ 40.2
Certificates of deposit	1.4	—	—	1.4
Money market funds	19.0	—	—	19.0
U.S. government securities	22.0	—	(0.1)	21.9
Total	$ 82.6	$ —	$ (0.1)	$ 82.5

Realized gains or losses related to sales and redemptions of restricted investments were not material for the years ended December 31, 2014, 2013, or 2012.

8. PROPERTY, EQUIPMENT AND CAPITALIZED SOFTWARE

Property, equipment and capitalized software and related accumulated depreciation is as follows:

	December 31,	
	2014	2013
Leasehold improvements	$ 26.1	$ 22.2
Computer equipment	69.3	62.9
Capitalized software	256.9	185.4
Furniture and equipment	26.4	22.4
	378.7	292.9
Less accumulated depreciation	(191.6)	(145.5)
Total property and equipment, net	$ 187.1	$ 147.4

We recognized depreciation expense on property, equipment and capitalized software of $46.8 million, $36.7 million, and $29.2 million for the years ended December 31, 2014, 2013, and 2012, respectively, including amortization expense on capitalized software of $30.4 million, $22.0 million and $15.4 million for the years ended December 31, 2014, 2013, and 2012, respectively.

9. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

A summary of changes in our goodwill by reportable business segment is as follows for 2014 and 2013:

	Medicaid Health Plans	Medicare Health Plans	Total
Balance as of December 31, 2012	$ 111.1	$ 112.7	$ 223.8
Acquisitions and acquisition related adjustments	15.7	(2.7)	13.0
Balance as of December 31, 2013[1]	126.8	110.0	236.8
Acquisitions and acquisition related adjustments	26.0	0.4	26.4
Balance as of December 31, 2014[1]	$ 152.8	$ 110.4	$ 263.2

(1) Cumulative impairment charges relating to goodwill were $78.3 million as of December 31, 2014 and 2013, which related to goodwill assigned to our Medicare Health Plans reporting unit which we impaired during 2008.

Other intangible assets as of December 31, 2014 and 2013, and the related weighted-average amortization periods as of December 31, 2014, are as follows:

	As of December 31,						
	2014				2013		
	Weighted Average Amortization Period (In Years)	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net
Provider networks	15.2	$ 9.9	$ (3.0)	$ 6.9	$ 6.1	$ (2.5)	$ 3.6
Licenses and permits	15.0	7.7	(3.4)	4.3	5.3	(2.9)	2.4
Trademarks and tradenames	12.8	15.9	(10.0)	5.9	13.3	(8.1)	5.2
Membership and state contracts	12.3	93.2	(14.2)	79.0	56.6	(6.4)	50.2
Other	7.3	5.7	(0.8)	4.9	6.4	(1.3)	5.1
Total other intangible assets	12.5	$ 132.4	$ (31.4)	$ 101.0	$ 87.7	$ (21.2)	$ 66.5

We recorded amortization expense of $13.1 million, $7.4 million, and $2.3 million for the years ended December 31, 2014, 2013 and 2012, respectively. The increase in amortization expense for 2014 resulted from the 2014 acquisitions of Windsor and Healthfirst NJ, and the 2013 acquisitions of WCSC and Missouri Care. Amortization expense expected to be recognized during fiscal years subsequent to December 31, 2014 is as follows:

	Expected Amortization Expense
2015	$ 11.1
2016	11.1
2017	10.6
2018	9.9
2019	9.7
2020 and thereafter	48.6
Total	$ 101.0

10. FAIR VALUE MEASUREMENTS

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value due to the short period of time between the origination of these instruments and the expected realization or payment.

For other financial instruments, including short- and long-term investments, restricted investments, amounts accrued related to investigation resolution, and long-term debt, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Assets and liabilities measured at fair value are classified using the following hierarchy, which is based upon the transparency of inputs to the valuation as of the measurement date.

Level 1—Quoted (unadjusted) prices for identical assets or liabilities in active markets: We include investments in commercial paper, money market funds, cash, U.S. government securities and the variable rate bond fund, as well as certain certificates of deposit and corporate debt, asset-backed and other municipal securities in Level 1. The carrying amounts of money market funds and cash approximate fair value because of the short-term nature of these instruments. We base fair values of the other investments included in Level 1 on unadjusted quoted market prices for identical securities in active markets.

Level 2—Inputs other than quoted prices in active markets: We include in Level 2 investments in certain certificates of deposit, corporate debt, asset-backed and other municipal securities for which fair market valuations are based on quoted prices for identical securities in markets that are not active, quoted prices for similar securities in active markets, broker or dealer quotations, or alternative pricing sources or for which all significant inputs are observable, either directly or indirectly, including interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks, and default rates.

In addition to using market data, we make assumptions when valuing our assets and liabilities, including assumptions about risks inherent in the inputs to the valuation technique. When there is not an observable market price for an identical or similar asset or liability, we use an income approach reflecting our best assumptions regarding expected cash flows, discounted using a commensurate risk-adjusted discount rate. We estimated the fair value of the future payments related to investigation resolution using a discounted cash flow analysis and recorded these amounts at fair value in the short- and long-term portions of amounts accrued related to investigation resolution line items in our consolidated balance sheets.

Level 3—Unobservable inputs that cannot be corroborated by observable market data: We hold investments in auction rate securities, designated as available for sale and reported at fair value. At December 31, 2014, the auction rate securities had par values of $34.1 million. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven or 35 days. Auctions for these auction rate securities continued to fail during the twelve months ended December 31, 2014. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Based on our analysis of anticipated cash flows, we have determined that it is more likely than not that we will be able to hold these securities until maturity or until market stability is restored. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Based on this, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. Significant unobservable inputs used in the discounted cash flow model include the historical municipal bond index return rate and individual security credit ratings. Increases or decreases in the municipal bond index return rate or changes in security credit ratings could result in a significant change in the fair value estimation of our auction rate securities. Unobservable inputs included in our estimation of fair value of auction rate securities at December 31, 2014 included security credit ratings ranging from AAA/Aaa to BB-/Ba3 and historical municipal bond index returns ranging from 0% to 6.0%. The fair values of auction rate securities are based on an approach that relies heavily on management assumptions and qualitative observations and therefore fall within Level 3 of the fair value hierarchy.

We determine transfers between levels at the end of the reporting period. No transfers between levels were recognized for the years ended December 31, 2014 and 2013.

Recurring Fair Value Measurements

Assets and liabilities measured at fair value on a recurrring basis at December 31, 2014 are as follows:

		Fair Value Measurements Using		
	Carrying Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Asset backed securities	$ 23.3	$ —	$ 23.3	$ —
Auction rate securities	32.3	—	—	32.3
Certificates of deposit	0.3	—	0.3	—
Corporate debt securities	138.6	—	138.6	—
Money market funds	41.4	41.4	—	—
Municipal securities	87.3	—	87.3	—
U.S. government and agency obligations	21.7	16.8	4.9	—
Variable rate bond fund	85.2	85.2	—	—
Total investments	$ 430.1	$ 143.4	$ 254.4	$ 32.3
Restricted investments:				
Money market funds	$ 65.9	$ 65.9	$ —	$ —
Cash	53.3	53.3	—	—
Certificates of deposit	1.0	—	1.0	—
U.S. government and agency obligations	30.1	30.1	—	—
Total restricted investments	$ 150.3	$ 149.3	$ 1.0	$ —
Amounts payable related to investigation resolution	$ 35.2	$ —	$ 35.2	$ —

Assets and liabilities measured at fair value on a recurring basis at December 31, 2013 are as follows:

	Carrying Value	Fair Value Measurements Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Asset backed securities	$ 1.6	$ —	$ 1.6	$ —
Auction rate securities	31.8	—	—	31.8
Certificates of deposit	1.6	—	1.6	—
Corporate debt securities	102.9	—	102.9	—
Money market funds	43.4	43.4	—	—
Municipal securities	108.9	—	108.9	—
U.S. government securities	19.6	19.6	—	—
Variable rate bond fund	85.3	85.3	—	—
Total investments	$ 395.1	$ 148.3	$ 215.0	$ 31.8
Restricted investments:				
Money market funds	$ 19.0	$ 19.0	$ —	$ —
Cash	40.2	40.2	—	—
Certificates of deposit	1.4	—	1.4	—
U.S. government securities	21.9	21.9	—	—
Total restricted investments	$ 82.5	$ 81.1	$ 1.4	$ —
Amounts payable related to investigation resolution	$ 70.3	$ —	$ 70.3	$ —

The following table presents the changes in the fair value of our Level 3 auction rate securities for the years ended December 31, 2014, 2013 and 2012:

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3): December 31, 2014	December 31, 2013	December 31, 2012
Balance as of January 1	$ 31.8	$ 32.0	$ 32.4
Realized gains (losses) in earnings	—	—	—
Changes in net unrealized gains and losses in other comprehensive income	0.5	(0.2)	0.4
Purchases, sales and redemptions	—	—	(0.8)
Net transfers in or (out) of Level 3	—	—	—
Balance as of December 31	$ 32.3	$ 31.8	$ 32.0

As a result of the increase (or decrease) in the fair value of our investments in auction rate securities, we recorded net unrealized gains (losses) of $0.5 million, $(0.2) million, and $0.4 million to accumulated other comprehensive loss during the years ended December 31, 2014, 2013 and 2012, respectively. There were no material redemptions or sales of our auction rate securities during the years ended December 31, 2014 and 2013, however, during the year ended December 31, 2012, we redeemed $0.8 million auction rate securities at par. We did not realize any losses associated with selling or redeeming our auction rate securities in 2012.

Debt

The following table presents the carrying value and fair value of our Senior Notes and Term Loan as of December 31, 2014, and our senior notes as of December 31, 2013:

	December 31, 2014	December 31, 2013
Long term debt	$ 900.0	$ 600.0
Approximate fair value of our long-term debt	908.7	615.0

The fair value of our Senior Notes was determined based on quoted market prices at December 31, 2014 and December 31, 2013, respectively, and therefore would be classified within Level 1 of the fair value hierarchy. The fair value of our Term Loan at December 31, 2014 was determined based on a discounted cash flow analysis, and would therefore be classified within Level 2 of the fair value hierarchy.

11. MEDICAL BENEFITS PAYABLE

Medical benefits payable consists of:

	As of December 31, 2014	% of Total	As of December 31, 2013	% of Total
IBNR	$ 1,111.5	75%	$ 690.1	72%
Other medical benefits payable	372.3	25%	263.3	28%
Total medical benefits payable	$ 1,483.8	100%	$ 953.4	100%

A reconciliation of the beginning and ending balances of medical benefits payable is as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Beginning balance	$ 953.4	$ 733.0	$ 744.8
Acquisitions	107.0	71.6	—
Medical benefits incurred related to:			
Current period	11,481.4	8,333.2	6,450.5
Prior period	(26.2)	(74.6)	(146.6)
Total	11,455.2	8,258.6	6,303.9
Medical benefits paid related to:			
Current period	(10,089.6)	(7,490.6)	(5,754.9)
Prior periods	(942.2)	(619.2)	(560.8)
Total	(11,031.8)	(8,109.8)	(6,315.7)
Ending balance	$ 1,483.8	$ 953.4	$ 733.0

Our estimates of medical benefits expense recorded at December 31, 2014, 2013 and 2012 developed favorably by approximately $26.2 million, $74.6 million, and $146.6 million in 2014, 2013 and 2012, respectively. The release of the provision for moderately adverse conditions included in our prior period estimates was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the favorable development in our estimate of medical benefits payable related to claims incurred in prior years does not directly correspond to a decrease in medical benefits expense recognized during the period.

Excluding the prior period development related to the release of the provision for moderately adverse conditions, our estimates of medical benefits expense recorded at December 31, 2014 developed unfavorably by approximately $48.1 million compared to favorable development of $3.0 million and $76.7 million in 2013 and 2012, respectively. The unfavorable development recognized in 2014 was due to higher than expected medical services in our Medicaid and Medicare Health Plan

segments that were not discernible until the impact became clearer over time as claim payments were processed. The favorable development in 2013 was due mainly to the medical cost trend emerging favorably in our Medicaid segment due to lower utilization. The favorable development in 2012 was due to the medical cost trend emerging favorably, mostly in our Medicaid segment and to a lesser extent in our MA and PDP segments, primarily due to lower than projected utilization, partially offset by higher than expected medical services in Kentucky.

Our acquisitions in 2012, 2013 and 2014 resulted in increases to medical benefits payable as of the effective date for each of the acquisitions. See Note 3, *Acquisitions*, for additional information.

12. DEBT

Credit Arrangements

In September 2014, we amended and restated our existing credit agreement (as amended and restated, the "Credit Agreement") to provide for a $300.0 million term loan (the "Term Loan") in addition to the previously-existing senior unsecured revolving loan facility (the "Revolving Credit Facility") of up to $300.0 million, which may be used for general corporate purposes of the Company and its subsidiaries. The Revolving Credit Facility provides that up to $75.0 million may be used for letters of credit. The Credit Agreement also provides that we may, at our option, increase the aggregate amount of the Revolving Credit Facility and/or obtain incremental term loans in an amount up to $75.0 million without the consent of any lenders not participating in such increase, subject to certain customary conditions and lenders committing to provide the increase in funding. The Term Loan matures in September 2016, with no amortization payments or prepayment penalties. We are not able to re-borrow amounts repaid under the Term Loan. The commitments under the Revolving Credit Facility expire on November 14, 2018 and any amounts outstanding under the facility will be payable in full at that time. Borrowings under the Credit Agreement bear interest at a rate of LIBOR plus a spread between 1.50% and 2.625%, or a rate equal to the Prime Rate plus a spread between 0.50% to 1.625%, depending upon our cash flow leverage ratio (which is defined as the ratio of our total debt to total consolidated EBITDA.) Unutilized commitments under the Credit Agreement are subject to a fee of 0.25% to 0.45% depending upon our cash flow leverage ratio.

The Credit Agreement contains negative and financial covenants that limit certain activities of our company and its subsidiaries, including (i) restrictions on our ability to incur additional indebtedness; and (ii) financial covenants that require (a) the cash flow leverage ratio not to exceed a maximum; (b) a minimum interest expense and principal payment coverage ratio; and (c) a minimum level of statutory net worth for our health maintenance organization and insurance subsidiaries. The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Revolving Credit Facility. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required immediately to repay all amounts outstanding under the Credit Agreement. Lenders holding at least 50% of the loans and commitments under the Credit Agreement may elect to accelerate the maturity of the loans and/or terminate the commitments under the Credit Agreement upon the occurrence and during the continuation of an event of default.

We received net proceeds of $298.6 million in connection with the funding of the Term Loan and closing of the Credit Agreement in September 2014. The Term Loan is classified as long-term debt in the Company's consolidated balance sheet at December 31, 2014 based on its September 2016 maturity date. The interest rate on the Term Loan was 2.50% as of December 31, 2014.

As of December 31, 2014 and as of the date of this filing, we have not drawn upon the Revolving Credit Facility and we remain in compliance with all covenants under both the Credit Agreement and the Senior Notes (defined below).

Additionally, in November 2013, we terminated our senior secured credit facility dated August 1, 2011, as amended to date, (the "2011 Credit Agreement") in connection with our entry into the Credit Agreement described above. All amounts outstanding under the 2011 Credit Agreement as of November 14, 2013, which amounted to $336.5 million, were paid in full upon termination of the agreement. In conjunction with the extinguishment of debt, we incurred approximately $2.8 million for the accelerated recognition of previously deferred financing costs.

Senior Notes due 2020

In November 2013, we completed the offering and sale of $600.0 million aggregate principal amount of 5.75% unsecured senior notes due 2020 (the "Senior Notes"). The aggregate net proceeds from the issuance of the Senior Notes were $587.9 million, with a portion of the net proceeds from the offering being used to repay the full $336.5 million outstanding under the 2011 Credit Agreement, and the remaining net proceeds were used for general corporate purposes, including organic growth opportunities. The Senior Notes will mature on November 15, 2020, and bears interest at a rate of 5.75% per annum. Interest is

computed on the basis of a 360-day year comprised of twelve 30-day months. Interest on the Senior Notes is payable semi-annually on May 15 and November 15 of each year, and commenced on May 15, 2014.

The Senior Notes were issued under an indenture, dated as of November 14, 2013 (the "Base Indenture"), as supplemented by the First Supplemental Indenture, dated as of November 14, 2013 (the "First Supplemental Indenture" and, together with the Base Indenture, the "Indenture") each between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The indenture under which the notes were issued contain covenants that, among other things, limit our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;
- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;
- incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, and in the case of the our subsidiaries, guarantee indebtedness;
- engage in transactions with affiliates;
- create unrestricted subsidiaries; and
- merge or consolidate with other entities.

Ranking and Optional Redemption

The Senior Notes are senior obligations of our company and rank equally in right of payment with all of our other existing and future unsecured and unsubordinated indebtedness. In addition, the Senior Notes will be structurally subordinated to all indebtedness and other liabilities of our subsidiaries (unless our subsidiaries become guarantors of the Senior Notes). We may redeem up to 40% of the aggregate principal amount of the Senior Notes at any time prior to November 15, 2016, at a redemption price equal to 105.75% of the principal amount of the Senior Notes redeemed, plus accrued and unpaid interest.

On or after November 15, 2016, we may on any one or more occasions redeem all or part of the Senior Notes, at the redemption prices (expressed as percentages of principal amount) set forth below, if redeemed during the twelve-month period beginning on November 15 of the years indicated below, subject to the rights of holders of Senior Notes on the relevant record date to receive interest due on the relevant interest payment date:

Period	Redemption Price
2016	102.875%
2017	101.438%
2018 and thereafter	100%

The Senior Notes are classified as long-term debt in the Company's Consolidated Balance Sheet at December 31, 2014 based on their November 2020 maturity date.

13. COMMITMENTS AND CONTINGENCIES

Government Investigations

Under the terms of settlement agreements entered into on April 26, 2011, and finalized on March 23, 2012, to resolve matters under investigation by the Civil Division of the U.S. Department of Justice ("Civil Division") and certain other federal and state enforcement agencies (the "Settlement"), we agreed to pay the Civil Division a total of $137.5 million in four annual installments of $34.4 million over 36 months plus interest accrued at 3.125%. The estimated fair value of the discounted remaining liability, and related interest, was $35.2 million at December 31, 2014, all of which has been included in the current amounts payable related to the investigation resolution in the accompanying consolidated balance sheet as of December 31, 2014.

The Settlement also provides for a contingent payment of an additional $35.0 million in the event that we are acquired or otherwise experience a change in control on or before April 30, 2015, provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Settlement.

Securities Class Action Complaint

In December 2010, we entered into a Stipulation and Agreement of Settlement (the "Stipulation Agreement") with the lead plaintiffs in the consolidated securities class action *Eastwood Enterprises, L.L.C. v. Farha, et al.*, Case No. 8:07-cv-1940-VMC-EAJ. The Stipulation Agreement requires us to pay to the class 25% of any sums we recover from Todd Farha, Paul Behrens and/or Thaddeus Bereday related to the same facts and circumstances that gave rise to the consolidated securities class action. Messrs. Farha, Behrens and Bereday are three former executives that were implicated in the government investigations of the Company that commenced in 2007.

Corporate Integrity Agreement

We operate under a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with the Office of Inspector General of the United States Department of Health and Human Services ("OIG-HHS"). The Corporate Integrity Agreement has a term of five years from its effective date of April 26, 2011 and mandates various ethics and compliance programs designed to help ensure our ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, WellCare's reporting practices and bid submissions to federal health care programs.

Indemnification Obligations

Under Delaware law, our charter and bylaws and certain indemnification agreements to which we are a party, we are obligated to indemnify, or we have otherwise agreed to indemnify, certain of our current and former directors, officers and associates with respect to current and future investigations and litigation, including the matters discussed in this footnote. The indemnification agreements for our directors and executive officers with respect to events occurring prior to May 2009 require us to indemnify an indemnitee to the fullest extent permitted by law if the indemnitee was or is or becomes a party to or witness or other participant in any proceeding by reason of any event or occurrence related to the indemnitee's status as a director, officer, employee agent or fiduciary of the Company or any of our subsidiaries and all expenses, including attorney's fees, judgments, fines, settlement amounts and interest and other charges, and any taxes as a result of the receipt of payments under the indemnification agreement. We will not indemnify the indemnitee if not permitted under applicable law. We are required to advance all expenses incurred by the indemnitee. We are entitled to reimbursement by an indemnitee of expenses advanced if the indemnitee is not permitted to be reimbursed under applicable law after a final judicial determination is made and all rights of appeal have been exhausted or lapsed.

We amended and restated our indemnification agreements in May 2009. The revised agreements apply to our officers and directors with respect to events occurring after that time. Pursuant to the 2009 indemnification agreements, we will indemnify the indemnitee against all expenses, including attorney's fees, judgments, penalties, fines, settlement amounts and any taxes imposed as a result of payments made under the indemnification agreement incurred in connection with any proceedings that relate to the indemnitee's status as a director, officer or employee of the Company or any of our subsidiaries or any other enterprise that the indemnitee was serving at our request. We will also indemnify for expenses incurred by the indemnitee if an indemnitee, by reason of his or her corporate status, is a witness in any proceeding. Further, we are required to indemnify for expenses incurred by an indemnitee in defense of a proceeding to the extent the indemnitee has been successful on the merits or otherwise. Finally, if the indemnitee is involved in certain proceedings as a result of the indemnitee's corporate status, we are required to advance the indemnitee's reasonable expenses incurred in connection with such proceeding, subject to the requirement that the indemnitee repay the expenses if it is ultimately determined that the indemnitee is not entitled to be indemnified. We are not obligated to indemnify an indemnitee for losses incurred in connection with any proceeding if a determination has not been made by the Board of Directors, a committee of disinterested directors or independent legal counsel in the specific case that the indemnitee has satisfied any standards of conduct required as a condition to indemnification under Section 145 of the Delaware General Corporation Law.

Pursuant to our obligations, we have advanced, and will continue to advance, legal fees and related expenses to three former officers and two additional associates who were criminally indicted in connection with the government investigations of the Company that commenced in 2007 related to federal criminal health care fraud charges including conspiracy to defraud the United States, false statements relating to health care matters, and health care fraud in connection with their defense of criminal charges. In June 2013, the jury in the criminal trial reached guilty verdicts on multiple charges for the four individuals that were tried in 2013. In May 2014, the individuals were sentenced and our request for restitution was denied. All four individuals filed notices of appeal and the government has filed notices of cross appeal on three of the four individuals, which the government subsequently voluntarily dismissed. The fifth individual is expected to be tried after the appeals have been decided.

We have also previously advanced legal fees and related expenses to these five individuals regarding disputes in Delaware Chancery Court related to whether we were legally obligated to advance fees or indemnify certain of these executives; the class actions titled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al. filed in federal court; six stockholder derivative actions filed in federal and state courts between October 2007 and January 2008; an investigation by the United States Securities & Exchange Commission (the "Commission"); and an action by the Commission filed in January 2012 against Messrs. Farha, Behrens and Bereday. The Delaware Chancery Court cases have concluded. We settled the class actions in May 2011. In 2010, we settled the stockholder derivative actions and we were realigned as the plaintiff to pursue our claims against Messrs. Farha, Behrens and Bereday. These actions, as well as the action by the Commission, have been stayed until at least 90 days after the conclusion of the criminal trial (including post-trial motions and proceedings).

In connection with these matters, we have advanced to the five individuals, cumulative legal fees and related expenses of approximately $185.9 million from the inception of the investigations to December 31, 2014. We incurred $30.0 million, $46.0 million and $38.2 million of these legal fees and related expenses during the years ended December 31, 2014, 2013 and 2012, respectively. We expense these costs as incurred and classify the costs as selling, general and administrative expense incurred in connection with the investigations and related matters.

In August 2010, we entered into an agreement and release with the carriers of our directors and officers ("D&O") liability insurance relating to coverage we sought for claims relating to the previously disclosed government investigations and related litigation. We accepted payment of $32.5 million prior to 2012 in satisfaction of the $45.0 million face amount of the relevant D&O insurance policies and the carriers agreed to waive any rights they may have to challenge our coverage under the policies. As a result, we have exhausted our insurance policies related to reimbursement of our advancement of fees related to these matters.

We expect the continuing cost of our obligations to the five individuals in connection with their defense and appeal of criminal charges and related litigation to be significant and to continue for a number of years. We are unable to estimate the total amount of these costs or a range of possible loss. Accordingly, we continue to expense these costs as incurred. Even if it is eventually determined that we are entitled to reimbursement of the advanced expenses, it is possible that we may not be able to recover all or any portion of our advances. Our indemnification obligations and requirements to advance legal fees and expenses may have a material adverse effect on our financial condition, results of operations and cash flows.

Other Lawsuits and Claims

Based on the nature of our business, we are subject to regulatory reviews or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance and benefits companies and their reviews focus on numerous facets of our business, including claims payment practices, provider contracting, competitive practices, commission payments, privacy issues and utilization management practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to our business practices. We continue to be subject to such reviews, which may result in additional fines and/or sanctions being imposed or additional changes in our business practices.

Separate and apart from the legal matters described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We review relevant information with respect to litigation matters and we update our estimates of reasonably possible losses and related disclosures. We accrue an estimate for contingent liabilities, including attorney's fees related to these matters, if a loss is probable and estimable. Currently, we do not expect that the resolution of any currently pending actions, either individually or in the aggregate, will differ materially from our current estimates or have a material adverse effect on our results of operations, financial position, and cash flows. However, the outcome of any legal actions cannot be predicted, and therefore, actual results may differ from those estimates.

Operating Leases

We recorded rental expense of $25.2 million, $20.4 million, and $17.0 million for the years ended December 31, 2014, 2013 and 2012, respectively, related to our operating leases for office space. Future minimum lease payments under non-cancelable operating leases with initial or remaining lease terms in excess of one year at December 31, 2014 are as follows:

	Minimum Lease Payments
2015	$ 24.9
2016	15.9
2017	12.1
2018	7.4
2019	4.1
2020 and thereafter	8.0
Total	$ 72.4

14. INCOME TAXES

The Company and subsidiaries file a consolidated federal income tax return and separate state franchise, income and premium tax returns, as applicable. The following table provides components of income tax expense (benefit):

	For the Years Ended December 31,		
	2014	2013	2012
Current:			
Federal	$ 105.1	$ 78.6	$ 84.0
State	15.1	7.5	8.6
	120.2	86.1	92.6
Deferred:			
Federal	(5.7)	16.0	18.1
State	(0.4)	0.9	1.0
	(6.1)	16.9	19.1
Total income tax expense	$ 114.1	$ 103.0	$ 111.7

A reconciliation of income tax at the statutory federal rate of 35% to income tax at the effective rate is as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Income tax expense at statutory federal rate	$ 62.2	$ 97.4	$ 103.7
Adjustments resulting from:			
State income tax, net of federal benefit	9.4	5.8	6.7
Tax exempt bargain purchase gain	(10.3)	—	—
Non-deductible executive compensation	3.8	5.1	2.4
Non-deductible amounts related to investigation resolution	0.1	(6.9)	(1.3)
Non-deductible ACA industry fees	48.2	—	—
Interest on unrecognized tax benefits	—	—	(0.1)
Other, net	0.7	1.6	0.3
Total income tax expense	$ 114.1	$ 103.0	$ 111.7

Our effective income tax rate on pre-tax income was 64.2% for the year ended December 31, 2014, compared to 37.0% for the year ended December 31, 2013 and 37.7% for the year ended December 31, 2012. The higher 2014 effective rate mainly reflects the impact of the non-deductible ACA industry fee. Additionally, the effective rate was lower in 2013 due to an issue resolution agreement reached with the IRS regarding the tax treatment of the investigation-related litigation and other resolution costs, resulting in approximately $7.6 million in additional tax benefit over what was recorded as of December 31, 2012. These unfavorable impacts were partially offset by the favorable impact of the Windsor bargain purchase gain.

Significant components of our deferred tax assets and liabilities are:

	As of December 31,	
Deferred tax assets:	2014	2013
Medical and other benefits discounting	$ 14.2	$ 11.7
Unearned premium discounting	6.4	—
Tax basis assets	10.1	10.1
Allowance for doubtful accounts	10.1	3.6
Amount payable related to investigation resolution	6.8	13.7
Accrued expenses and other	18.6	19.0
	66.2	58.1
Deferred tax liabilities:		
Goodwill, other intangible assets and property and equipment	3.5	26.0
Software development costs	68.9	54.9
Prepaid assets	5.1	8.9
	77.5	89.8
Net deferred tax liability	$ (11.3)	$ (31.7)

We have not recorded a valuation allowance at December 31, 2014 and 2013 as we expect that we will fully realize our deferred tax assets.

We classify deferred tax assets and liabilities in the consolidated balance sheets as follows:

	As of December 31,	
	2014	2013
Current assets	$ 37.1	$ 23.7
Non-current liabilities	(48.4)	(55.4)
Net deferred tax liability	$ (11.3)	$ (31.7)

In September 2014, the IRS issued final regulations on the ACA's $0.5 million limit on the deduction for compensation paid to service providers of a covered health insurance provider under Code section 162(m)(6). As a result, we no longer believe the deduction limitations apply to WellCare, and we reversed $10.4 million of previously recorded tax expense from prior periods during the year ended December 31, 2014. However, we are not able to conclude at this time that our tax position is more likely than not to be sustained upon IRS CAP review. Therefore, we recognized a liability for unrecognized tax benefits amounting to $10.4 million at December 31, 2014. The unrecognized tax benefit, if recognized, would reduce the effective tax rate.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

	Years Ended December 31,	
	2014	2013
Gross unrecognized tax benefits, beginning of period	$ —	$ —
Gross increases:		
Prior year tax positions	—	—
Current year tax positions	10.4	—
Gross decreases:		
Prior year settlements	—	—
Prior year tax positions	—	—
Statute of limitations lapses	—	—
Gross unrecognized tax benefits, end of period	$ 10.4	$ —

We believe it is reasonably possible that our liability for unrecognized tax benefits will not significantly increase or decrease in the next twelve months as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

We classify interest and penalties associated with uncertain income tax positions as income taxes within our consolidated financial statements. We did not incur or record interest and accrued penalties for the years ended December 31, 2014 and 2013.

We file our income tax returns in the U.S. federal jurisdiction and various states. The IRS has concluded its CAP review of our 2012 tax return as well as all the prior years. We expect the IRS will conclude its CAP review of our 2013 tax return, with the exception of the compensation deduction limitation issue under Code section 162(m)(6), in 2015. We are no longer subject to state and local tax examinations prior to 2004. As of December 31, 2014, we are not aware of any material proposed adjustments.

15. EQUITY-BASED COMPENSATION

We recorded equity-based compensation expense of $15.7 million, $12.5 million and $14.9 million for the years ended December 31, 2014, 2013, and 2012, respectively. As of December 31, 2014, we expect $25.6 million of unrecognized compensation cost related to non-vested equity-based compensation arrangements, net of estimated forfeitures, to be recognized over a weighted-average period of 1.8 years. The unrecognized compensation cost for our PSUs, which are subject to variable accounting, was determined based on the closing common stock price of $82.06 as of December 31, 2014 and amounted to approximately $11.4 million of the total unrecognized compensation. Due to the nature of the accounting for these awards, future compensation cost will fluctuate based on changes in our common stock price.

The weighted-average grant-date fair values of shares granted during the years ended December 31, 2014, 2013, and 2012 were $64.49, $61.33, and $64.19, respectively. The total fair value of all shares vested during the year ended December 31, 2014 was $11.4 million. We generally repurchase vested shares to satisfy tax withholding requirements and then retire the repurchased shares.

Stock Options

We have not granted stock option awards since 2010, but some remain outstanding. A summary of our stock option activity for the year ended December 31, 2014, and the aggregate intrinsic value and weighted average remaining contractual term for our stock options as of December 31, 2014, is:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Years)
Outstanding as of January 1, 2014	31,381	$ 29.47		
Granted	—	—		
Exercised	(21,954)	26.98		
Forfeited and expired	(1,407)	14.49		
Outstanding as of December 31, 2014 (1)	8,020	38.92	$ 0.3	0.2

(1) All of the Company's outstanding stock options were vested and exercisable as of December 31, 2014.

The total intrinsic value of options exercised during the years ended December 31, 2014, 2013, and 2012 was $0.9 million, $14.1 million, and $9.8 million, respectively.

For the years ended December 31, 2014, 2013, and 2012, we received cash from option exercises of $0.5 million, $10.3 million, and $9.4 million, respectively. We currently expect to satisfy equity-based compensation awards with available unissued registered shares.

Restricted Stock and RSUs

A summary of the activity for our restricted stock and RSU awards for the year ended December 31, 2014 is:

	Restricted Stock and RSUs	Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2014	259,836	$ 56.51
Granted	325,336	64.65
Vested	(116,132)	57.46
Forfeited and expired	(62,137)	59.95
Outstanding as of December 31, 2014	406,903	62.23

MSUs

A summary of the activity for our MSU awards for the year ended December 31, 2014 is:

	MSUs	Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2014	83,889	$ 79.38
Granted	74,784	71.42
Vested	—	—
Forfeited and expired	(45,010)	78.97
Outstanding as of December 31, 2014	113,663	74.31

PSUs

A summary of the activity for our PSU awards, which are subject to variable accounting, for the year ended December 31, 2014 is:

	PSUs	Weighted Average Award-Issuance Fair Value
Outstanding as of January 1, 2014	288,487	$ 55.30
Granted	270,417	62.38
Vested	(62,640)	40.57
Forfeited and expired	(101,189)	60.61
Outstanding as of December 31, 2014	395,075	61.13

16. RELATED-PARTY TRANSACTIONS

The Graham Companies

We lease office space from The Graham Companies, in which a member of the board of directors and his immediate family has a 23% ownership interest. We paid $0.2 million in rental expense to The Graham Companies in each of the years ended December 31, 2014 and 2013, and $0.1 million in rental expense in the year ended December 31, 2012.

17. REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Each of our health maintenance organizations ("HMO") and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, risk-based capital ("RBC") requirements or other financial ratios. Failure to maintain these requirements would trigger regulatory action by the state. Such statues, regulations and capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries that may not be transferable to us in the form of loans, advances, or cash dividends was approximately $746.0 million at December 31, 2014, and $489.0 million at December 31, 2013. The combined statutory capital and surplus of our HMO and insurance subsidiaries was $1.3 billion and $1.1 billion at December 31, 2014 and 2013, respectively, which was in compliance with the minimum capital requirements as of those dates.

Dividend restrictions vary by state, but the maximum amount of dividends which can be paid without prior approval from the applicable state is subject to restrictions relating to statutory capital, surplus and net income for the previous year. Some states require prior approval of all dividends, regardless of amount. States may disapprove any dividend that, together with other dividends paid by a subsidiary in the prior 12 months, exceeds the regulatory maximum as computed for the subsidiary based on its statutory surplus and net income. We received $68.0 million, $147.0 million and $192.0 million in dividends from our regulated subsidiaries during the years ended December 31, 2014, 2013, and 2012, respectively. The 2014 amount included $36 million not requiring prior regulatory approval, and $32 million paid after obtaining prior regulatory approval. Under applicable regulatory requirements at December 31, 2014, the amount of dividends that may be paid through the end of 2015 by our HMO and insurance subsidiaries without prior approval by regulatory authorities is approximately $60.0 million in the aggregate.

18. EMPLOYEE BENEFIT PLANS

401(k) Plan

We offer a defined contribution 401(k) plan. Eligible employees of the Company and its subsidiaries may elect to participate in this plan. Participants may contribute a certain percentage of their compensation, subject to maximum Federal and plan limits. We incurred matching contribution expense of $7.9 million, $6.0 million and $4.3 million during the years ended December 31, 2014, 2013 and 2012, respectively.

Long-term Incentive Program

Certain of our senior level employees, including executive officers, are eligible for long-term incentive awards ("LTI Program"), consisting of a mix of cash and equity awards, which are granted pursuant to the 2013 Incentive Compensation Plan during 2013 and 2014 and the 2004 Equity Incentive Plan during 2012 and certain prior years. We designed the LTI Program to motivate and promote the achievement of our long-term financial and operating goals and improve retention. Under the LTI Program, we grant multi-year performance period awards that are not realized by employees and officers until subsequent years. We base award amounts on each participant's pre-established long-term incentive target and allocate the awards to various types of equity awards and performance-based cash, depending on job level. The Compensation Committee has sole discretion of the ultimate funding and payout of awards under the LTI program. We accrued compensation costs related to the LTI Program performance-based cash bonus of $1.0 million and $5.2 million as of December 31, 2014 and 2013, respectively.

19. QUARTERLY FINANCIAL INFORMATION

Selected unaudited quarterly financial data is as follows (in millions, except membership and per share data):

	For the Three Month Periods Ended			
	March 31, 2014	June 30, 2014[1]	September 30, 2014	December 31, 2014[2]
Total revenues	$ 2,985.7	$ 3,151.9	$ 3,407.5	$ 3,414.8
Gross margin	312.9	268.9	365.0	375.8
Income (loss) from operations	37.3	(14.6)	69.5	56.1
Income (loss) before income taxes[3]	65.6	(3.5)	61.7	54.0
Net income (loss)	44.1	(7.5)	19.3	7.7
Net income (loss) per share - basic	$ 1.01	$ (0.17)	$ 0.44	$ 0.18
Net income (loss) per share - diluted	1.00	(0.17)	0.44	0.18
Period end membership	3,530,000	3,874,000	4,037,000	4,119,000

(1) During the second quarter of 2014, we recognized approximately $24.1 million in impairment and other charges, $18.0 million of which primarily relates to the partial impairment of certain intangible assets recorded in the 2012 acquisition of Easy Choice. The remaining charges also include a charge for the full impairment of intangible assets associated with the purchase of our Arizona MA plan after we concluded during 2014 to exit the Arizona MA market in 2015, and charges resulting from the resolution of certain matters related to the purchase price of our 2013 acquisitions.
(2) In the three months ended December 31, 2014, we recognized $4.6 million in net out of period adjustments that decreased income (loss) before income taxes, mainly related to reductions in Medicaid revenues associated with rate changes that occurred in previous quarters in 2014. We have evaluated the effects of these adjustments, both quantitatively and qualitatively, and concluded that they are not material to any prior quarterly or annual period impacted.
(3) The estimated fair value of the net tangible and intangible assets that we acquired in connection with the Windsor acquisition has exceeded the total consideration paid, and payable, to the seller. We recognized the excess fair value as a bargain purchase gain, in accordance with accounting rules related to business combinations, after consideration of all relevant factors, which resulted in gains of approximately $28.3 million and $11.1 million in the first and second quarters of 2014, and charges of $7.8 million and $2.1 million in the third and fourth quarters of 2014.

	For the Three Month Periods Ended			
	March 31, 2013	June 30, 2013	September 30, 2013	December 31, 2013
Total revenues	$ 2,256.6	$ 2,332.1	$ 2,500.4	$ 2,438.8
Gross margin	265.0	311.5	350.9	323.1
Income from operations	**22.9**	**77.2**	**106.8**	**74.2**
Income before income taxes	22.9	77.2	106.8	71.4
Net income	**21.5**	**46.9**	**64.0**	**42.9**
Net income per share - basic	$ 0.50	$ 1.08	$ 1.47	$ 0.98
Net income per share - diluted	0.49	1.07	1.45	0.97
Period end membership	2,703,000	2,842,000	2,824,000	2,846,000

The sum of the quarterly amounts may not equal the amount reported for the full year due to rounding. Additionally, per share amounts are computed independently for each quarter and for the full year based on respective weighted-average shares outstanding and other dilutive potential shares and units.

Schedule I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
STATEMENTS OF COMPREHENSIVE INCOME
(In millions)

	For the Years Ended December 31,		
	2014	2013	2012
Revenues:			
Investment and other income	$ 0.9	$ 0.2	$ 0.1
Total revenues	**0.9**	**0.2**	**0.1**
Expenses:			
Selling, general and administrative	**18.1**	**15.2**	**17.4**
Interest expense	39.3	11.8	4.0
Total expenses	**57.4**	**27.0**	**21.4**
Loss from operations	(56.5)	(26.8)	(21.3)
Loss on extinguishment of debt	**—**	**(2.8)**	**—**
Loss before income taxes	(56.5)	(29.6)	(21.3)
Income tax benefit	**17.5**	**8.9**	**5.7**
Loss before equity in subsidiaries	(39.0)	(20.7)	(15.6)
Equity in earnings of subsidiaries	**102.7**	**196.0**	**200.3**
Net income	63.7	175.3	184.7
Other comprehensive income, before tax:			
Change in net unrealized gains and losses on available-for-sale securities	0.5	(0.8)	1.5
Income tax expense related to other comprehensive income	**(0.2)**	**(0.3)**	**0.6**
Other comprehensive income (loss), net of tax	0.7	(0.5)	0.9
Comprehensive income	**$ 64.4**	**$ 174.8**	**$ 185.6**

See notes to consolidated financial statements.

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
BALANCE SHEETS
(In millions, except share data)

	As of December 31,	
	2014	2013
Assets		
Current Assets:		
Cash and cash equivalents	$ 1.4	$ 271.3
Investments	36.9	2.3
Taxes receivable	3.6	2.6
Affiliate receivables and other current assets	876.6	364.7
Total current assets	918.5	640.9
Deferred tax asset	11.6	7.9
Investment in subsidiaries	1,568.4	1,465.1
Deposits and other assets	8.8	10.1
Total Assets	$ 2,507.3	$ 2,124.0
Liabilities and Stockholders' Equity		
Current liabilities	$ 5.1	$ 6.1
Long-term debt	900.0	600.0
Other liabilities	6.3	—
Total liabilities	911.4	606.1
Commitments and contingencies (see Note 13)	—	—
Stockholders' Equity:		
Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, $0.01 par value (100,000,000 authorized, 43,914,106 and 43,766,645 shares issued and outstanding at December 31, 2014 and December 31, 2013, respectively)	0.4	0.4
Paid-in capital	503.0	489.4
Retained earnings	1,093.1	1,029.4
Accumulated other comprehensive loss	(0.6)	(1.3)
Total stockholders' equity	1,595.9	1,517.9
Total Liabilities and Stockholders' Equity	$ 2,507.3	$ 2,124.0

See notes to consolidated financial statements.

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
STATEMENTS OF CASH FLOWS
(In millions)

	For the Years Ended December 31,		
	2014	2013	2012
Net cash provided by (used in) operating activities	$ 83.4	$ 204.9	$ (23.3)
Cash used in investing activities:			
Net proceeds (payments) from purchases and sales and maturities of investments	(33.9)	—	0.9
Payments to subsidiaries, net	(616.0)	(398.5)	(41.1)
Net cash used in investing activities	(649.9)	(398.5)	(40.2)
Cash provided by (used in) financing activities:			
Proceeds from debt, net of financing costs paid	298.6	816.4	(0.6)
Proceeds from exercises of stock options	0.5	10.3	9.4
Incremental tax benefit from equity-based compensation	0.6	3.6	3.8
Repurchase and retirement of shares to satisfy tax withholding requirements	(3.1)	(4.1)	(6.5)
Payments on debt	—	(365.0)	(11.3)
Net cash provided by (used in) financing activities	296.6	461.2	(5.2)
Cash and cash equivalents:			
(Decrease) increase during year	(269.9)	267.6	(68.7)
Balance at beginning of year	271.3	3.7	72.4
Balance at end of year	$ 1.4	$ 271.3	$ 3.7

See notes to consolidated financial statements.

Schedule II — Valuation and Qualifying Accounts
(In millions)

	Balance at Beginning of Period	Charged to Costs and Expenses	Write Offs	Balance at End of Period
Year Ended December 31, 2014				
Deducted from assets:				
Allowance for uncollectible accounts:				
Premiums receivable	$ 15.8	$ 15.2	$ 9.9	$ 21.1
Receivables for non-member claims paid	—	—	—	—
Medical advances	1.4	—	—	1.4
Total	$ 17.2	$ 15.2	$ 9.9	$ 22.5
Year Ended December 31, 2013				
Deducted from assets:				
Allowance for uncollectible accounts:				
Premiums receivable	$ 14.8	$ 10.7	$ 9.7	$ 15.8
Receivables for non-member claims paid	—	—	—	—
Medical advances	1.5	(0.1)	—	1.4
Total	$ 16.3	$ 10.6	$ 9.7	$ 17.2
Year Ended December 31, 2012				
Deducted from assets:				
Allowance for uncollectible accounts:				
Premiums receivable	$ 10.4	$ 14.8	$ 10.4	$ 14.8
Receivables for non-member claims paid	4.0	1.6	5.6	—
Medical advances	1.3	0.2	—	1.5
Total	$ 15.7	$ 16.6	$ 16.0	$ 16.3

Exhibit Index

Exhibit Number	Description	INCORPORATED BY REFERENCE		
		Form	Filing Date with SEC	Exhibit Number
3.1	Amended and Restated Certificate of Incorporation of the Registrant	10-Q	August 13, 2004	3.1
	a. First Amendment to Amended and Restated Certificate of Incorporation	10-Q	November 4, 2009	3.1.1
	b. Second Amendment to Amended and Restated Certificate of Incorporation	8-K	May 28, 2014	3.1
3.2	Third Amended and Restated Bylaws of the Registrant	8-K	November 2, 2010	3.2
4.1	Specimen common stock certificate	10-Q	November 4, 2010	4.1
4.2	Base Indenture, dated November 14, 2013 between WellCare Health Plans, Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee	8-K	November 18, 2013	4.1
	a. First Supplemental Indenture, dated November 14, 2013 between WellCare Health Plans, Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.75% Senior Note due 2020)	8-K	November 18, 2013	4.2
10.1	Registration Rights Agreement, dated as of September 6, 2002, by and among WellCare Holdings, LLC and certain equity holders	S-1	February 13, 2004	10.13
MATERIAL AGREEMENTS RELATING TO COMPENSATION AND INDEMNIFICATION				
2013 Incentive Compensation Plan and Forms Adopted Thereunder				
10.2	**Registrant's 2013 Incentive Compensation Plan***	DEF 14A	April 10, 2013	A
10.3	**Forms of Agreement under Registrant's 2013 Incentive Compensation Plan**			
	a. Form of Performance Stock Unit Award Notice and Agreement*	8-K	May 22, 2013	10.1
	b. Form of Performance Stock Unit Award Agreement*	8-K	May 22, 2013	10.2
	c. Form of Performance Stock Unit Award Notice and Agreement with deferral provisions*	8-K	May 22, 2013	10.3
	d. Form of Performance Stock Unit Award Agreement with deferral provisions*	8-K	May 22, 2013	10.4
	e. Form of Performance Stock Unit Award Notice and Agreement (for grants dated September 2, 2014) *	8-K	September 4, 2014	10.1
	f. Form of Market Stock Unit Award Notice and Agreement*	8-K	May 22, 2013	10.5
	g. Form of Market Stock Unit Award Agreement*	8-K	May 22, 2013	10.6
	h. Form of Market Stock Unit Award Notice and Agreement with deferral provisions*	8-K	May 22, 2013	10.7
	i. Form of Market Stock Unit Award Agreement with deferral provisions*	8-K	May 22, 2013	10.8
	j. Form of Restricted Stock Unit Award Notice and Agreement (employee version)*	8-K	May 22, 2013	10.9
	k. Form of Restricted Stock Unit Award Agreement (employee version)*	8-K	May 22, 2013	10.10
	l. Form of Restricted Stock Unit Award Notice and Agreement with deferral provisions (employee version)*	8-K	May 22, 2013	10.11

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
	m. Form of Restricted Stock Unit Award Agreement with deferral provisions (employee version)*	8-K	May 22, 2013	10.12
	n. Form of Restricted Stock Unit Award Notice and Agreement (director version)*	8-K	May 22, 2013	10.13
	o. Form of Restricted Stock Unit Award Agreement (director version)*	8-K	May 22, 2013	10.14
	p. Form of Restricted Stock Unit Award Notice and Agreement with deferral provisions (director version)*	8-K	May 22, 2013	10.15
	q. Form of Restricted Stock Unit Award Agreement with deferral provisions (director version)*	8-K	May 22, 2013	10.16
2004 Equity Incentive Plan and Forms Adopted Thereunder				
10.4	**Registrant's 2004 Equity Incentive Plan***	10-Q	August 13, 2004	10.4
10.5	**Forms of Stock Option Agreement under Registrant's 2004 Equity Incentive Plan**			
	a. Adopted in 2004 (Non-Qualified)*	10-Q	August 13, 2004	10.5
	b. Adopted in 2004 (Incentive)*	10-Q	August 13, 2004	10.6
	c. Adopted May 28, 2009 (Non-Qualified)*	8-K	June 3, 2009	10.4
	d. Adopted December 17, 2010*	8-K	December 20, 2010	10.6
10.6	**Forms of Restricted Stock Agreement under Registrant's 2004 Equity Incentive Plan**			
	a. Adopted May 28, 2009 (associate version)*	8-K	June 3, 2009	10.1
	b. Adopted May 28, 2009 (director version)*	8-K	June 3, 2009	10.2
10.7	**Forms of Restricted Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan**			
	a. Adopted May 28, 2009 (associate version)*	8-K	June 3, 2009	10.3
	b. Adopted March 31, 2010 (associate version)*	8-K	April 5, 2010	10.4
	c. Adopted August 4, 2010 (director version)*	10-Q	August 9, 2010	10.5
	d. Adopted December 17, 2010 (associate version)*	8-K	December 20, 2010	10.2
	e. Adopted December 17, 2010 (with deferral feature; associate version)*	8-K	December 20, 2010	10.3
	f. Adopted February 13, 2012 (form of notice; associate version)*	8-K	February 17, 2012	10.9
	g. Adopted February 13, 2012 (form of agreement; associate version)*	8-K	February 17, 2012	10.10
	h. Adopted February 13, 2012 (with deferral feature; form of notice; associate version)*	8-K	February 17, 2012	10.11
	i. Adopted February 13, 2012 (with deferral feature; form of agreement; associate version)*	8-K	February 17, 2012	10.12
	j. Adopted February 13, 2012 (form of notice; director version)*	8-K	February 17, 2012	10.13
	k. Adopted February 13, 2012 (form of agreement; director version)*	8-K	February 17, 2012	10.14
	l. Adopted February 13, 2012 (with deferral feature; form of notice; director version)*	8-K	February 17, 2012	10.15
	m. Adopted February 13, 2012 (with deferral feature; form of agreement; director version)*	8-K	February 17, 2012	10.16
10.8	**Forms of Performance Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan**			
	a. Adopted March 31, 2010*	8-K	April 5, 2010	10.3
	b. Adopted December 17, 2010*	8-K	December 20, 2010	10.4
	c. Adopted December 17, 2010 (with deferral feature)*	8-K	December 20, 2010	10.5

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
	d. Amendment adopted March 24, 2011 (amending agreements on forms adopted March 31, 2010 and December 17, 2010)*	**8-K**	**March 28, 2011**	**10.4**
	e. Adopted March 24, 2011*	8-K	March 28, 2011	10.1
	f. Adopted March 24, 2011 (with deferral feature)*	**8-K**	**March 28, 2011**	**10.2**
	g. Adopted February 13, 2012 (notice)*	8-K	February 17, 2012	10.1
	h. Adopted February 13, 2012 (agreement)*	**8-K**	**February 17, 2012**	**10.2**
	i. Adopted February 13, 2012 (with deferral feature; form of notice)*	8-K	February 17, 2012	10.3
	j. Adopted February 13, 2012 (with deferral feature; form of agreement)*	**8-K**	**February 17, 2012**	**10.4**
	k. Adopted March 18, 2013 (form of notice)*	8-K	March 22, 2013	10.1
	l. Adopted March 18, 2013 (with deferral feature; form of notice)*	**8-K**	**March 22, 2013**	**10.3**
10.9	**Forms of Market Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan**			
	a. Adopted February 13, 2012 (form of notice)*	**8-K**	**February 17, 2012**	**10.5**
	b. Adopted February 13, 2012 (form of agreement)*	8-K	February 17, 2012	10.6
	c. Adopted February 13, 2012 (with deferral feature; form of notice)*	**8-K**	**February 17, 2012**	**10.7**
	d. Adopted February 13, 2012 (with deferral feature; form of agreement)*	8-K	February 17, 2012	10.8
	e. Adopted March 18, 2013 (form of notice)*	**8-K**	**March 22, 2013**	**10.5**
	f. Adopted March 18, 2013 (with deferral feature; form of notice)*	8-K	March 22, 2013	10.7
10.10	**Forms of Deferred Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan**			
	a. Adopted August 4, 2010 (director version)*	10-Q	August 9, 2010	10.6
Other Compensation and Indemnification Plans and Forms of Agreement				
10.11	**WellCare Holdings, LLC 2002 Senior Executive Equity Plan***	**S-1**	**February 13, 2004**	**10.14**
10.12	Form of Subscription Agreement under 2002 Senior Executive Equity Plan*	S-1	February 13, 2004	10.15
10.13	**Form of Director Subscription Agreement***	**10-K**	**February 14, 2006**	**10.14**
10.14	Form of Non-Plan Time Vesting Option Agreement*	10-K	February 14, 2006	10.20
10.15	**WellCare Holdings, LLC 2002 Employee Option Plan***	**S-1**	**February 13, 2004**	**10.16**
10.16	Form of Time Vesting Option Agreement under 2002 Employee Option Plan*	S-1	February 13, 2004	10.17
10.17	**Long Term Incentive Cash Bonus Plan (with form of Award Agreement adopted March 31, 2010)***	**10-Q**	**May 6, 2010**	**10.5**
	a. Form of Award Agreement (adopted March 24, 2011)*	8-K	March 28, 2011	10.3
10.18	**Amended and Restated Annual Cash Bonus Plan (adopted May 4, 2013)***	**10-Q**	**August 7, 2013**	**10.18**
10.19	WellCare Health Plans, Inc. Executive Severance Plan (as amended and restated December 12, 2013)*	8-K	January 27, 2014	10.2
	a. Amended and restated as of December 12, 2013 (with non-substantive revisions)*	**8-K**	**November 5, 2014**	**10.2**
10.20	Non-Employee Director Compensation Policy as amended and effective December 13, 2013*	10-K	February 13, 2014	10.21
	a. Amended and restated (effective commencing February 27, 2014)*	**10-Q**	**May 9, 2014**	**10.4**

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
	b. Amended and restated (effective commencing April 1, 2014)*	10-Q	August 6, 2014	10.1
	c. Amended and restated (effective commencing December 12, 2014)* †			
10.21	**Forms of Indemnification Agreement**			
	a. Adopted May 16, 2003*	S-1/A	June 8, 2004	10.24
	b. Adopted May 8, 2009*	8-K	May 14, 2009	10.1
	c. Adopted August 5, 2010*	10-Q	August 9, 2010	10.8
Agreements with Individual Officers and Directors				
10.22	Separation Agreement and General Release for All Claims, dated as of January 25, 2008, by and among the Registrant, Comprehensive Health Management, Inc. and Todd S. Farha*	8-K	January 31, 2008	10.1
10.23	Form of Non-Qualified Stock Option Agreement between the Registrant and Thomas L. Tran*	8-K	July 17, 2008	10.4
10.24	Notice of Termination of Employment / Letter of Agreement between the Registrant and Thomas L. Tran dated February 20, 2014*	8-K	February 21, 2014	10.1
10.25	Summary of Employment Terms for David J. Gallitano*	8-K	November 1, 2013	10.1
10.26	Offer Letter, by and between Comprehensive Health Management, Inc. and Kenneth Burdick, dated January 7, 2014*	8-K	January 27, 2014	10.1
10.27	Offer Letter by and between Comprehensive Health Management, Inc. and Andrew Asher, dated August 12, 2014*	8-K	November 5, 2014	10.1
MATERIAL AGREEMENTS RELATING TO LITIGATION AND INVESTIGATIONS				
10.28	Stipulation and Agreement of Settlement dated December 17, 2010 between the Registrant and the lead plaintiffs in the matter *Eastwood Enterprises, LLC v. Farha, et al.* (Case No. 8:07-cv-1940-VMC-EAJ)	10-K	February 16, 2011	10.44
10.29	Settlement Agreement dated April 26, 2011 among the United States of America, the Registrant and certain of its subsidiaries and Relators Sean Hellein, Clark J. Bolton, Eugene Gonzalez, and SF United Partners	10-Q	May 2, 2012	10.20
	a. Settlement Agreement with the State of Connecticut	10-Q	August 3, 2011	10.3
	b. Settlement Agreement with the State of Florida	10-Q	August 3, 2011	10.4
	c. Settlement Agreement with the State of Georgia	10-Q	August 3, 2011	10.5
	d. Settlement Agreement with the State of Hawaii	10-Q	August 3, 2011	10.6
	e. Settlement Agreement with the State of Illinois	10-Q	August 3, 2011	10.7
	f. Settlement Agreement with the State of Indiana	10-Q	August 3, 2011	10.8
	g. Settlement Agreement with the State of Missouri	10-Q	August 3, 2011	10.9
	h. Settlement Agreement with the State of New York	10-Q	August 3, 2011	10.10
	i. Settlement Agreement with the State of Ohio	10-Q	August 3, 2011	10.11
10.30	Corporate Integrity Agreement dated April 26, 2011 between the Office of the Inspector General of the Department of Health and Human Services and the Registrant	10-Q	August 3, 2011	10.1

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
MATERIAL OPERATIONAL AGREEMENTS				
10.31	Credit Agreement, dated November 14, 2013, among WellCare Health Plans, Inc., the lenders party thereto, JPMorgan Chase Bank, N.A., as administrative agent, SunTrust Bank and Goldman Sachs Bank USA as co-syndication agents and J.P. Morgan Securities LLC, Suntrust Robinson Humphrey, Inc. and Goldman Sachs Bank USA as joint bookrunners and joint lead arrangers	8-K	November 18, 2013	10.1
	a. Amended and Restated Credit Agreement, dated September 25, 2014, among WellCare Health Plans, Inc., the lenders party thereto, JPMorgan Chase Bank, N.A., as administrative agent, Bank of America, N.A., MUFG Union Bank, N.A. and U.S. Bank National Association as co-documentation agents	8-K	September 25, 2014	10.7
10.32	Contract No. FP020 by and between AHCA and Staywell (Florida MMA 2014-2018)	10-Q	May 9, 2014	10.10
	a. Minor Modification No. 1	10-Q	August 6, 2014	10.5
	b. Amendment No. 1	10-Q	August 6, 2014	10.6
	c. Amendment No. 2	10-Q	August 6, 2014	10.7
	d. Amendment No. 3	8-K	October 9, 2014	10.1
	e. Amendment No. 4	10-Q	November 5, 2014	10.9
	f. Minor Modification No. 2 †			
	g. Minor Modification No. 3 †			
10.33	Contract No. FA972 by and between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a HealthEase (Medicaid Non-Reform 2012-2015)	8-K	September 24, 2012	10.2
	a. Minor Modification No. 1	10-K	February 13, 2013	10.36.a
	b. Amendment No. 1	8-K	February 4, 2013	10.4
	c. Amendment No. 2	10-Q	May 3, 2013	10.4
	d. Amendment No. 3	10-Q	November 1, 2013	10.7
	e. Amendment No. 4	10-K	February 13, 2014	10.34.e
	f. Amendment No. 5	8-K	January 15, 2014	10.2
	g. Amendment No. 6	8-K	April 3, 2014	10.2
	h. Minor Modification No. 2	10-Q	August 6, 2014	10.4
	i. Amendment No. 7	8-K	January 26, 2015	10.2
10.34	Contract No. FA971 by and between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a d/b/a Staywell Health Plan of Florida (Medicaid Non-Reform 2012-2015)	8-K	September 24, 2012	10.1
	a. Amendment No. 1	10-K	February 13, 2013	10.38.a
	b. Amendment No. 2	8-K	February 4, 2013	10.3
	c. Amendment No. 3	10-Q	May 3, 2013	10.2
	d. Amendment No. 4	10-Q	November 1, 2013	10.5
	e. Amendment No. 5	10-Q	November 1, 2013	10.6
	f. Amendment No. 6	10-K	February 13, 2014	10.35.f
	g. Amendment No. 7	8-K	January 15, 2014	10.1
	h. Amendment No. 8	8-K	April 3, 2014	10.1
	i. Minor Modification No. 1	10-Q	August 6, 2014	10.3
	j. Amendment No. 9	8-K	January 26, 2015	10.1
10.35	Amendment No. 12 to Contract 0654 (Amended and Restated Contract 0654) by and between the Georgia Department of Community Health and WellCare of Georgia**†			

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
	a. Amendment No. 13**	8-K	January 5, 2012	10.2
	b. Amendment No. 14	10-Q	October 31, 2012	10.12
	c. Amendment No. 15**	8-K	March 27, 2013	10.4
	d. Amendment No. 16	8-K	April 14, 2014	10.2
	e. Amendment No. 17**	8-K	January 6, 2014	10.1
	f. Amendment No. 18**	8-K	January 21, 2014	10.1
10.36	Letter Agreement dated March 3, 2014 from the Georgia Department of Community Health to WellCare of Georgia, Inc.	8-K	March 6, 2014	10.1
10.37	Medicaid Managed Care Contract dated July 6, 2011, between WellCare Health Insurance Company of Kentucky, Inc. (f/k/a WellCare Health Insurance of Illinois, Inc., d/b/a WellCare of Kentucky, Inc.) and the Commonwealth of Kentucky, Finance and Administration Cabinet	10-K	February 13, 2013	10.40
	a. Amendment No. 1	10-Q	May 3, 2013	10.5
	b. Amended and Restated Contract	10-K	February 14, 2014	10.37.b
	c. Amendment No. 1 to Amended and Restated Contract	8-K	January 9, 2014	10.1
	d. Amendment No. 2 to Amended and Restated Contract	8-K	September 15, 2014	10.1
10.38	Contract S5967 between the Centers for Medicare & Medicaid Services and WellCare Prescription Insurance, Inc.			
	a. 2014 plan year contract	8-K	October 2, 2013	10.1
	b. 2015 plan year contract	8-K	September 15, 2014	10.2
10.39	Contract H1032 between the Centers for Medicare & Medicaid Services and WellCare of Florida, Inc.			
	a. 2014 plan year contract	8-K	October 2, 2013	10.2
	b. 2015 plan year contract	8-K	September 15, 2014	10.3
21.1	List of subsidiaries †			
23.1	Consent of Deloitte & Touche LLP †			
31.1	Certification of Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
32.1	Certification of Chief Executive Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
32.2	Certification of Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
101.INS	XBRL Instance Document ††			
101.SCH	XBRL Taxonomy Extension Schema Document ††			
101.CAL	XBRL Taxonomy Calculation Linkbase Document ††			
101.DEF	XBRL Taxonomy Definition Linkbase Document ††			
101.LAB	XBRL Taxonomy Labels Linkbase Document ††			
101.PRE	XBRL Taxonomy Presentation Linkbase Document ††			

* Denotes a management contract or compensatory plan, contract or arrangement

** Portions of this exhibit have been omitted pursuant to a request for confidential treatment.

† Filed herewith

†† Furnished herewith and not filed for purposes of Section 11 and Section 12 of the Securities Act of 1933 and Section 18 of the Securities Exchange Act of 1934

BOARD OF DIRECTORS

Christian P. Michalik
Chairman of the Board,
WellCare Health Plans, Inc., and
Managing Director,
Kinderhook Industries

Richard C. Breon
President and Chief Executive Officer,
Spectrum Health System

Kenneth A. Burdick
Chief Executive Officer,
WellCare Health Plans, Inc.

Carol J. Burt
Principal, Burt-Hilliard Investments

Roel C. Campos
Partner, Locke Lord LLP

David J. Gallitano
Former Chairman of the Board and
Former Interim Chief Executive Officer,
WellCare Health Plans, Inc.

D. Robert Graham
Chair of the Board of Oversight,
Bob Graham Center for Public Service

Kevin F. Hickey
Principal, HES Advisors

Glenn D. Steele, Jr., M.D.
President and Chief Executive Officer,
Geisinger Health System

William L. Trubeck
Former Executive Vice President
and Chief Financial Officer,
H&R Block, Inc.

Paul E. Weaver
Former Vice Chairman,
PricewaterhouseCoopers, LLP

EXECUTIVE OFFICERS

Kenneth A. Burdick
Chief Executive Officer

Lawrence D. Anderson
Senior Vice President and
Chief Human Resources Officer

Andrew L. Asher
Senior Vice President and
Chief Financial Officer

Steven E. Goldberg
Senior Vice President and
Chief Medical Officer

Michael R. Polen
Senior Vice President, Operations

Blair W. Todt
Senior Vice President,
Chief Legal and Administrative
Officer and Secretary

Michael C. Yount
Senior Vice President and
Chief Compliance Officer

CORPORATE INFORMATION

Corporate Headquarters
WellCare Health Plans, Inc.
8725 Henderson Road
Tampa, Florida 33634
(813) 290-6200
www.wellcare.com

Common Stock
WellCare Health Plans, Inc.'s common stock is listed on the New York Stock Exchange under the trading symbol WCG. Matters regarding change of address and other stock issues should be directed to the stockholder relations department of the transfer agent.

Financial Information
Investment community members seeking information about WellCare may contact Investor Relations by calling (813) 206-6958, visiting www.wellcare.com on the Internet, or writing to WellCare Investor Relations at P.O. Box 31379, Tampa, Florida 33631-3379.

Transfer Agent
Computershare Trust Company, N.A.
PO Box 43078
Providence, Rhode Island 02940-3078
(781) 575-2879
www.computershare.com

Independent Registered Public Accounting Firm
Deloitte & Touche LLP
Tampa, Florida

Vision

Our vision is to be the leader in government-sponsored health care programs in partnership with the members, providers, governments and communities we serve.

Mission

Our primary mission is to:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Values

Partnership. Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.

Integrity. Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.

Accountability. All associates must be responsible for the commitments we make and the results we deliver.

Teamwork. With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.

WellCare® Health Plans

WellCare Health Plans, Inc.
8725 Henderson Road
Tampa, Florida 33634
(813) 290-6200
www.wellcare.com

WELLS FARGO

Wells Fargo Commercial Banking
100 South Ashley Drive, Suite 1000
Tampa, FL 33602

November 20, 2015

To whom it may concern,

This letter is to certify that WellCare Health Plans, Inc. is a client and account holder at Wells Fargo Bank, N.A. WellCare has been a client for over 12 years, and our business relationship with WellCare is in positive standing.

Please feel free to contact me directly with further questions.

Sincerely,

Leslie Fredericks

Leslie Fredericks
SVP, Commercial Banking
Wells Fargo Bank, N.A.
MAC Z0307-102
100 S. Ashley Drive
Suite 1000
Tampa, Florida 33602
leslie.fredericks@wellsfargo.com
813.225.4318

Together we'll go far

CORPORATE OVERVIEW

C. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

WELLCARE DOES NOT ANTICIPATE A CHANGE IN OWNERSHIP OR CONTROL

WellCare does not anticipate any change in ownership or control during the 12 months following the proposal due date for either WellCare or WellCare of Nebraska.

CORPORATE OVERVIEW

D. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

MEETING MEMBERS WHERE THEY ARE: A NEBRASKA SOLUTION

WellCare's mission is to deliver culturally-competent, locally-based care to our members on behalf of our state partners. To achieve this goal, we rely on becoming embedded in the local fabric of each state. For us this means having a main office location in the capital of the state where we are operating. Being easily accessible to our state partners facilitates a responsive and collaborative relationship.

Once awarded a contract, Lincoln will be the site of WellCare of Nebraska's main office. Plan leaders, government affairs associates and other senior staff will be based in this office location. Currently, we have an office located in Omaha at 1299 Farnam Street, Suite 300.

A Best-in-Class Solution

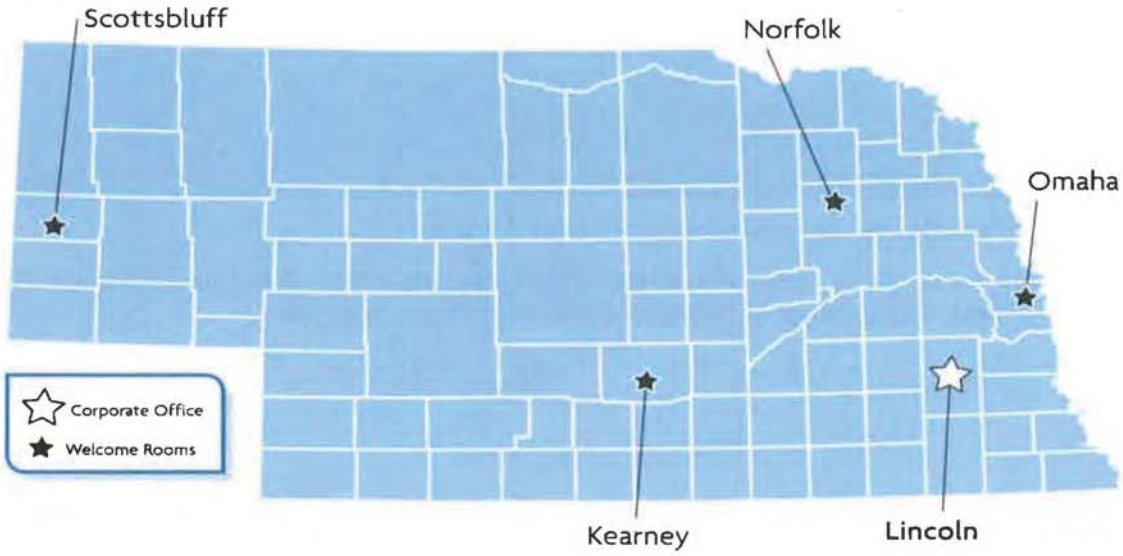
WellCare of Nebraska will operate four Welcome Rooms across the state in addition to our main office to better reach members in the communities in which they live, work and access care.

Not only do we have an office in Nebraska, but for months now, senior leadership from our corporate office in Tampa have traveled to Nebraska to establish relationships with providers, with advocates and community service organizations leaders. Out of these relationships and the local knowledge gleaned from them, we can prepare and plan for a truly Nebraska-oriented plan.

We recognize our Heritage Health members will be living across the entire state in urban, rural and frontier areas. To reach them, we will open Welcome Rooms (**Figure 1**) in strategic locations to make it easy for our members to access us. Housed in strategically selected, high traffic, retail shopping areas in the neighborhoods and communities where enrollees live, work and frequent, our Welcome Rooms are designed and equipped to engage the community by being outreach centers and walk-in member service hubs. Members and families can meet face-to-face with a member service representative at a local Welcome Room to get personalized attention to their needs. These locations are intended to be a destination point for our members and offer computers, internet access and activities geared toward our members and the community we serve. The Welcome Rooms will host events such as children's reading and literacy support classes, nutrition education classes, special needs resource navigation, and a variety of other activities and events for the community each month, becoming an important community resource. In Nebraska, we will have Welcome Rooms located in Omaha, Kearney, Scottsbluff and Norfolk. The size of the state and the locations where the majority of our membership lives drives the decision-making around the location of these offices. The map below (**Figure 2**) illustrates the breadth of our geographic scope and access for our members.

Figure 1: Welcome Room

Figure 2


Scottsbluff
Norfolk
Omaha
Corporate Office
Welcome Rooms
Kearney
Lincoln

CORPORATE OVERVIEW

E. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

DEALINGS WITH THE STATE OVER THE PREVIOUS FIVE YEARS

Neither WellCare nor any of its subsidiaries or predecessors has contracted, or had any other form of business arrangement, with the State of Nebraska during the previous five years.

CORPORATE OVERVIEW

F. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Sub-Contractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

WELLCARE DOES NOT EMPLOY ANY STATE EMPLOYEES

No party named in this proposal response is or was an employee of the State of Nebraska within the past 12 months.

No employee of any agency of the State of Nebraska is employed by WellCare or is a proposed Sub-Contractor to WellCare as of the due date for proposal submission.

CORPORATE OVERVIEW

G. CONTRACT PERFORMANCE

If the bidder or any proposed Sub-Contractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

CONTRACT TERMINATIONS IN THE PAST FIVE YEARS

WellCare

In the past five years, neither WellCare nor any of its subsidiaries has had a contract terminated for default or non-performance. However, during that period, two of WellCare's plans have had contracts to provide services to state prescription assistance programs ("SPAPs") terminated for reasons completely unrelated to our plans' performance. In each case, the SPAP sponsor de-funded the underlying SPAP program and, with no funds to pay for services, the administering agency terminated all contracts for services under those programs:

- **Illinois SPAP**: The Illinois General Assembly did not appropriate funds for the Illinois SPAP program for the state's 2013 fiscal year, which began July 1, 2012. At that time two WellCare subsidiaries, WellCare Prescription Insurance, Inc. (WellCare Rx) and Harmony Health Plan of Illinois, Inc., provided services to the Illinois SPAP program pursuant to Contracts 2010-22-005, each effective as of January 1, 2010, with the Illinois Department of Healthcare and Family Services (Illinois DHFS). As a result of the General Assembly's decision not to appropriate funds for the SPAP program, Illinois DHFS terminated all of its contracts with SPAP service providers as of July 1, 2012, including its contracts with WellCare Rx and Harmony. Contact information: Michelle Maher, Chief, Bureau of Managed Care, Illinois Department of Healthcare and Family Services, 201 South Grand Avenue East, Springfield, IL 62763; (217) 524-7478.
- **North Carolina SPAP**: From 2007 to 2011, North Carolina funded its SPAP program through the North Carolina Health and Wellness Trust Fund (HWTF), one of three entities created by the North Carolina General Assembly to administer funds received through a settlement between the state and tobacco manufacturers. However, the HWTF ceased funding the SPAP program as of June 30, 2011. At that time WellCare Rx provided services to the North Carolina SPAP program through Contract #90009208 dated January 13, 2010, with the North Carolina Department of Health and Human Services, Office of Rural Health and Community Care (North Carolina DHHS). With no funds with which to operate the SPAP program, North Carolina DHHS terminated all of its contracts with SPAP service providers as of June 30, 2011, including its contract with WellCare Rx. Contact information: John Price, North Carolina Department of Health and Human Services, Office of Rural Health and Community Care, 2009 Mail Service Center, Raleigh, NC 27699; (919) 527-6440. Please note that this is the most recent contact information we have; the program terminated four years ago.

In addition to the SPAP contracts above, we wanted to disclose the following. On February 16, 2015, the Iowa Department of Human Services ("DHS") issued Iowa Department of Human Services - Request for Proposal - Iowa High Quality Healthcare Initiative - RFP MED-16-009 (the "Iowa RFP"). On August 17, 2015, DHS issued a Notice of Intent to Award contracts arising out of the RFP to four entities including WellCare of Iowa, Inc. ("WCIA"). Three unsuccessful bidders filed bid protests challenging the intended contract awards. Those protests were denied and each of the protestors timely appealed the denial of their protests to the Iowa Department of Inspection and Appeals, Division of Administrative Hearings in the case styled *Iowa Total Care, Inc. et al. v. Iowa Department of Human Services, et al.*, Appeal Nos. 16001573, 16001590, and 16001623. During the pendency of those appeals, the winning bidders, including WCIA, entered into contracts with DHS on October 9, 2015. On November 25, 2015, following an administrative hearing, Administrative Law Judge Christie J. Scase issued a Proposed Decision which, among other things, reversed the Notice of Intent to Award a contract to WCIA. WCIA, DHS, and the protesting bidders each sought review of the Administrative Law Judge's Proposed Decision. Review was granted and on December 18, 2015, Iowa Department of Administrative Services Director Janet E. Phipps (the "Director") issued a Final Order reversing the Notice of Intent to Award to WCIA and terminating WCIA's contract with DHS. WCIA disputes the facts and law as set forth in both the Proposed Order and Final Order and will seek judicial review of the Final Order, including the Director's decision to terminate the contract between WCIA and DHS. DHS' contact person, address and phone number for purposes of the now terminated contract is:

Mikki Stier, Medicaid Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
515-256-4647

Proposed Sub-Contractors

All but one of WellCare's proposed Sub-Contractors has confirmed that they have not had a contract terminated for default or non-performance in the past five years. The remaining proposed Sub-Contractor, R.R. Donnelley & Sons Company (Donnelley), is a publicly traded company (NNM: RRD). Its net sales in 2014 were $11.6 billion and it has tens of thousands of contracts with customers all over the world. Because of the scope of its operations, Donnelley was unable to definitely confirm that in the last five years it has not had a single customer contract terminated for default or non-performance. However, Donnelley has confirmed that to the best of its knowledge and belief, no prior terminations would have a material impact on Donnelley's ability to provide products or services under the Request for Proposal.

CORPORATE OVERVIEW

H. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

I. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

a) The time period of the project;

b) The scheduled and actual completion dates;

c) The Contractor's responsibilities;

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

e) Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

II Contractor and Sub-Contractor(s) experience must be listed separately. Narrative descriptions submitted for Sub-Contractors must be specifically identified as Sub-Contractor projects.

III If the work was performed as a Sub-Contractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Sub-Contractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Sub-Contractor.

I. WELLCARE HAS EXTENSIVE RELEVANT EXPERIENCE SERVING MEDICAID MEMBERS

WellCare plans have been proud to serve Medicaid managed care members since 1994 and currently operate Medicaid plans in nine states covering 2.4 million members. All of our plans cover TANF and CHIP members and some of our plans cover aged, blind and disabled (ABD), SSI, members in long-term supports and services (LTSS), duals and/or foster children, giving us broad experience with the various members we would serve in Nebraska. Please find below summaries of our experience serving Medicaid managed care programs in three of our programs as requested – Florida, Hawaii and Kentucky. As would be the case for Nebraska, WellCare's plans have served government programs only as prime Contractors rather than as Sub-Contractors. Therefore we have not included a response for subsections II and III of this question.

Florida

a) ***Time period:*** WellCare of Florida, Inc. has served Florida Medicaid under successive contracts since 1994.

b) ***Scheduled and actual completion dates:*** WellCare of Florida's current contract with the Florida Agency for Health Care Administration (AHCA) expires on December 31, 2018. WellCare of Florida serves CHIP members ages 5 to 18 years under a separate contract with the Florida Healthy Kids Corporation (FHKC). WellCare of Florida's current contract with FHKC expires on September 30, 2017. It may be extended by FHKC for up to an additional two one-year periods, for a potential term through September 30, 2019.

c) ***Contractor's responsibilities:***

Populations currently served: TANF, SSI, CHIP, ABD, duals

Benefits currently covered: Comprehensive and integrated , including inpatient, outpatient, behavioral health, substance use disorder, pharmacy, dental, hearing, vision, laboratory, therapy, DME, home health, assistive care, transportation and hospice services.

Number of members currently served: As of September 30, 2015, WellCare of Florida served approximately 788,000 Medicaid and CHIP members.

WellCare of Florida is a fully capitated plan operating in eight of Florida's 11 Medicaid regions. The plan is responsible for ensuring the provision of services in sufficient amount, duration and scope to ensure the provision of all covered services under the contract. In particular, the following aspects of our experience in Florida will be valuable in serving our Heritage Health members:

- We serve a particularly diverse population
- We provide integrated medical and behavioral health services
- We provide services to aged, blind and disabled members
- Our members live in a mix of urban and rural settings

d) ***Customer name and contact information:*** Elizabeth Dudek, Secretary, Agency for Health Care Administration, (850) 412-4007 (phone), (850) 922-2897 (fax), Elizabeth.Dudek@ ahca.myflorida.com (email)

e) ***Whether work performed as the prime Contractor or as a Sub-Contractor:*** WellCare of Florida is contracted with AHCA as a prime Contractor.

Originally scheduled and actual completion date: As noted above, WellCare of Florida's current contract with AHCA is scheduled to expire December 31, 2018 and its current contract with FHKC is scheduled to expire September 30, 2019 (if extended for all additional terms).

Originally scheduled and actual budget: WellCare of Florida is paid a monthly capitation rate for the members enrolled in its plans, so there is no budget for these projects in the traditional sense.

- For calendar year 2014, WellCare of Florida projected Medicaid and CHIP premiums in an amount of $1,481,724,000; actual (reported) premiums for this period were $1,744,957,051
- For the period of January 1, 2015, through September 30, 2015 WellCare of Florida projected Medicaid and CHIP premiums in an amount of $1,553,129,000; actual (reported) premiums for this period were $1,696,144,738

Hawaii

a) ***Time period:*** WellCare Health Insurance of Arizona, Inc., d/b/a 'Ohana Health Plan, Inc. ('Ohana) has served the Hawaii Medicaid program under successive contracts since 2009.

b) ***Scheduled and actual completion dates:*** 'Ohana's current contract with the Hawaii Department of Human Services/Med-QUEST Division (DHS) to provide Medicaid managed care services (the "QUEST Integration Contract") expires on December 31, 2017 but may be extended by up to four additional one year terms for a potential term through December 31, 2021. Since 2013 'Ohana has also served as DHS's exclusive contractor under Hawaii's Community Care Services program. 'Ohana's Community Care Services (CCS) contract is scheduled to expire on June 30, 2016 but may be extended by up to two additional one year terms for a potential term through June 30, 2018.

c) ***Contractor's responsibilities:***

Populations currently served: TANF, SSI, CHIP, ABD, LTSS, duals

Benefits currently covered: Comprehensive and integrated, including inpatient, outpatient,

behavioral health, substance use disorder, LTSS, pharmacy, hearing, vision, laboratory, therapy, DME, home health, assistive care, transportation and hospice services.

Number of members currently served: As of September 30, 2015, 'Ohana served approximately 48,000 Medicaid and CHIP members.

'Ohana is a fully capitated plan operating on a statewide basis. The plan is responsible for providing for the direction, coordination, monitoring and tracking of the medical, behavioral health, and LTSS services needed by its members. Many 'Ohana members receive home and community-based services to help support their independence. In addition, 'Ohana coordinates additional behavioral health services for Medicaid-eligible adults who have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) under the CCS Contract. In particular, the following aspects of our experience in Hawaii will be valuable in serving our Heritage Health members:

- We serve a particularly diverse population
- We provide integrated medical and behavioral health services
- We provide services to aged, blind and disabled members
- Our members live in a mix of urban and rural settings

d) ***Customer name and contact information:*** Jon Fujii, Research Officer, Temporary Assignment, Health Care Services Branch Administrator, Department of Human Services, Med-QUEST Division, (808) 692-8093 (phone), (808) 692-8087 (fax), jfujii@ medicaid.dhs.state.hi.us (email)

e) ***Whether work performed as the prime Contractor or as a Sub-Contractor:*** 'Ohana is contracted with DHS as a prime Contractor.

Originally scheduled and actual completion date: As noted above, 'Ohana's current QUEST Integration Contract is scheduled to expire December 31, 2021 (if extended for all additional terms) and its CCS Contract is scheduled to expire June 30, 2018 (if extended for all additional terms).

Originally scheduled and actual budget: 'Ohana is paid a monthly capitation rate for the members enrolled in its plan, so there is no budget for this project in the traditional sense.

- For calendar year 2014, 'Ohana projected Medicaid and CHIP premiums in an amount of $514,829,000; actual (reported) premiums for this period were $513,596,844
- For the period of January 1, 2015, through September 30, 2015, 'Ohana projected Medicaid and CHIP premiums in an amount of $407,396,000; actual (reported) premiums for this period were $378,580,380

Kentucky

a) ***Time period:*** WellCare Health Insurance Company of Kentucky, Inc. d/b/a WellCare of Kentucky, Inc. has served the Kentucky Medicaid program under successive contracts since 2011.

b) ***Scheduled and actual completion dates:*** WellCare of Kentucky's current contract with the Commonwealth of Kentucky, Cabinet for Health and Family Services, Division of Medicaid Services (DMS) expires on June 30, 2016. The contract may be renewed for up to four additional one-year periods upon the mutual agreement of the parties. For a potential term through June 30, 2020.

c) ***Contractor's responsibilities:***

Populations currently served: TANF, CHIP, ABD, foster children, duals

Benefits currently covered: Comprehensive and integrated, including inpatient, outpatient, behavioral health, substance use disorder, pharmacy, dental, hearing, vision, laboratory, therapy, DME, home health, transportation and hospice services.

Number of members currently served: As of September 30, 2015, WellCare of Kentucky served

approximately 436,000 Medicaid and CHIP members.

WellCare of Kentucky is a fully capitated plan operating on a statewide basis. The plan is responsible for providing covered services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under Kentucky's fee-for-service program. In particular, the following aspects of our experience in Kentucky will be valuable in serving our Heritage Health members:

- We serve a particularly diverse population
- We provide integrated medical and behavioral health services
- We provide services to aged, blind and disabled members
- Our members live in a mix of urban and rural settings

d) ***Customer name and contact information:*** Don Speer, Executive Director, Kentucky Finance and Administration Cabinet, Office of Procurement Services, (502) 564-4510 (phone), (502) 564-1434 (fax), don.speer@ky.gov (email)

e) ***Whether work performed as the prime Contractor or as a Sub-Contractor:*** WellCare of Kentucky is contracted with DMS as a prime Contractor.

Originally scheduled and actual completion date: As noted above, the current contract between WellCare of Kentucky and DMS is scheduled to expire June 30, 2020 (if extended for all additional terms).

Originally scheduled and actual budget: WellCare of Kentucky is paid a monthly capitation rate for the members enrolled in its plan, so there is no budget for this project in the traditional sense.

- For calendar year 2014, , WellCare of Kentucky projected Medicaid and CHIP premiums in an amount of $1,726,528,000; actual (reported) premiums for this period were $2,290,331,769
- For the period of January 1, 2015, through September 30, 2015, WellCare of Kentucky projected Medicaid and CHIP premiums in an amount of $1,860,179,000; actual (reported) premiums for this period were $1,948,652,725

Other States

In addition to the above, WellCare plans currently serve Medicaid managed care members in the following states:

- Georgia (since 2006)
- Illinois (since prior to the plan's acquisition by WellCare in 2004)
- Missouri (since prior to the plan's acquisition by WellCare in 2013)
- New Jersey (since 2014)
- New York (since prior to the plan's acquisition by WellCare in 2002)
- South Carolina (since prior to the plan's acquisition by WellCare in 2013)

CORPORATE OVERVIEW

I. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and a minimum of three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

WellCare has developed an approach to managing the Heritage Health project that is centered on building a local fully integrated team while leveraging the decades of experience and solid expertise of the WellCare family of health plans through a corporate "shared services" structure. This two-pronged approach allows us an opportunity to leverage a robust pool of intellectual capital comprised of both instrumental local knowledge as well as national expertise.

As part of our process, we have identified key personnel to work on the project as we build up our local leadership team. These leaders have a broad depth of experience working with state Medicaid programs and implementing new plans, with a particular emphasis on an integrated approach to best meet the physical, behavioral, pharmacy and social needs of our members.

When we enter a new state, we consider a three-phased approach to managing the project:

- Strategy Development
- Implementation
- Continuing Operations.

We set up our processes to seamlessly move through phases and ensure institutional knowledge about the program is catalogued and passed from phase to phase.

Phase one, Strategy Development, begins even before an award is made. We value having identified people in a state who can help us determine the right strategies for the people of that state. In Nebraska, we have engaged consultants from the advocacy and provider communities to assist us, and we have dedicated WellCare staff members who have visited the state for more than year leading up to this procurement. This includes staff members experienced in integrated programs and in behavioral health specifically, as well as staff members engaged with our Health*Connections* and community advocacy program. The Strategy Development phase allows us to begin building important relationships and our core local knowledge base so that we can seamlessly and easily move into the Implementation phase. As described in greater detail below, during the implementation phase, our identified leadership will be supported by a robust set of rigorous standards for project governance and a team of project management professionals who are well versed in working with state Medicaid programs to bring up new plans through readiness and launch. Once we go live, we transition from implementation to ongoing operations

with a built-in "Rapid Response" structure in the early months to mitigate any challenges that arise when new populations or provider types come into managed care, particularly from traditional fee-for-service Medicaid.

Once fully into the continuing operations phase, the local WellCare of Nebraska leadership and staff will own the project with ongoing support from corporate operational functions and WellCare leadership.

From Implementation to Continuing Operations: WellCare's Approach to Project Management

WellCare values the process by which we must demonstrate to Nebraska's MLTC that we are ready to assume responsibility for contracted services. As part of implementation and readiness review process, we will maintain a detailed implementation plan with the understanding that it is subject to MLTC approval. This plan, already in development will detail tasks, staff responsibilities, timelines, milestones, contingencies and other processes which will ensure that contracted services begin at the agreed upon date. With our experience in other states, WellCare has developed a best-practices approach to project governance detailed below.

WellCare's Project Governance Team

The WellCare Corporate Enterprise Project Management Office (ePMO) "Market Initiatives Team" manages the implementation of State and Federal contracts for all markets and products. Our team is well-versed in standard Software Development Lifecycle (SDLC) waterfall and Agile planning and development methodologies. Our professional project managers leverage ePMO-developed, best-practice "Playbooks" that reflect years of industry experience and lessons learned across numerous contract implementations.

The ePMO works hand-in-hand with Market leaders, Government partners, other corporate business functions and SMEs, corporate IT, and ancillary vendors to ensure a compliant, operationally-sound Medicaid implementation that seamlessly transitions new members and providers into our health plan. The individuals staffed on the project are highly experienced and more specifically have worked previously implementing new programs including the introduction and/or expansion of Medicaid managed care in Kentucky, Georgia, Florida and New York.

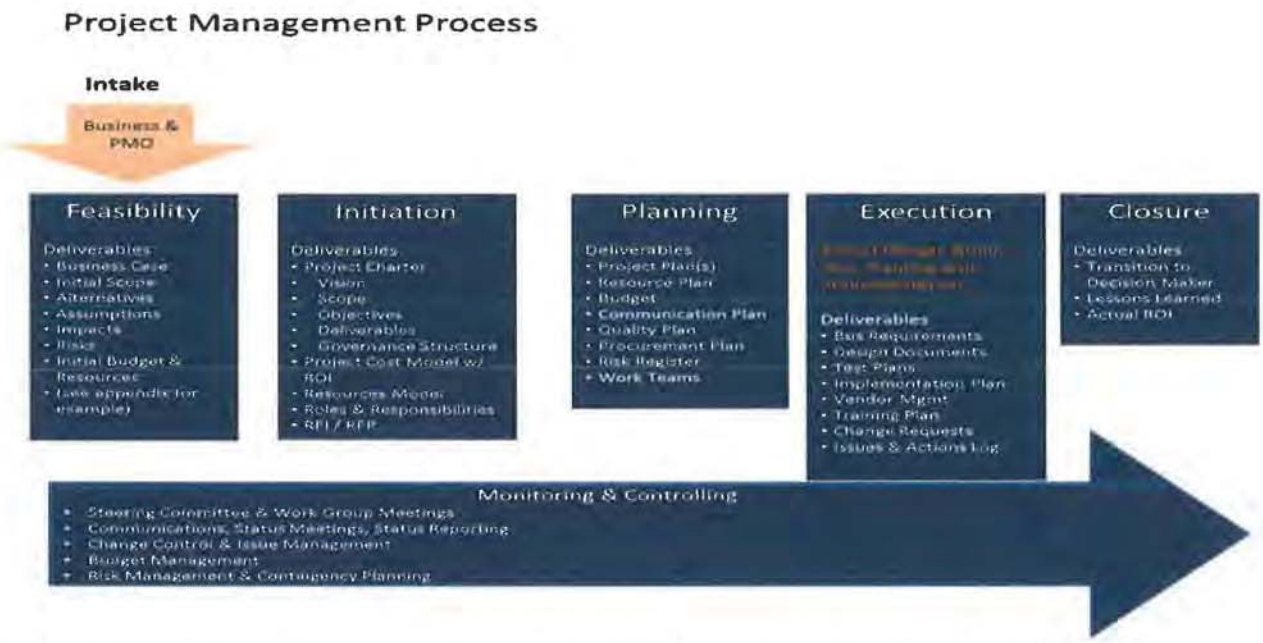
Project Governance Responsibilities

The ePMO's involvement begins early with the selection of a Senior Project Manager (PM) who monitors the RFP process and determines impacts to "People, Processes and Technology" associated with the requirements of the contract based on the RFP. The PM develops a high-level business requirements tool that documents any significant impacts, particularly those involving systems and technology. The PM then develops a high-level implementation plan that identifies tasks, milestones, and resource requirements.

To ensure we meet the specifications of the RFP and Scope of Work we incorporate a series of best practices, including the use of eleven cross-functional project work streams and underlying project teams that will manage end-to-end implementation activities. The eleven project streams include: contract to payment (claims), network development, enrolling a member (member services), member and provider communications, care coordination (includes grievance and appeals), quality and analytics (quality and utilization management), finance, training, regulatory compliance, information technology, and readiness delivery (transition and implementation).

We have already appointed governance team members to the various streams who will be responsible for all Nebraska implementation deliverables. The governance team will oversee the timely completion of activities on the implementation plan, ensure cross-team communication, identify issues, and provide weekly project status reports to our executive leadership team, to whom they are accountable. Once WellCare submits the RFP to the State, the PM launches the formal ePMO Project Management Process illustrated in **Figure 3.**

Figure 3



In the earliest stages of the project, the PM develops a high-level scope document, "MS Project" work plan, resource plan, organizational chart, budget, and risk document. The PM introduces these artifacts with the broader team at the Project Kick Off meeting, and continually refines them as the project progresses into later stages. The process is underscored by a cadence of regularly scheduled internal Steering Committee, Work Group, Status, Issue/Risk, and Change Control meetings to ensure effective communication, timely project delivery, issue resolution, scope control, and escalation to appropriate parties when necessary. The ePMO will also supply weekly status reports in a MLTC-approved format, including updates to the work plan and timeline, and participate in weekly status meetings with MLTC.

Following the implementation, we will provide ongoing management and oversight with unmatched rigor. In new market implementations such as this one, we have found it especially beneficial to supplement traditional operations oversight and the necessary reporting and analytics with ongoing and candid external stakeholder discussions. In addition, rigorous annual evaluations that go beyond traditional, obligatory utilization and quality management program evaluations provide us with even more actionable information. We will complete a comprehensive assessment of our compliance with the RFP and Scope of Work, which will include a detailed analysis of process and outcomes metrics. To supplement this internal review, our corporate compliance and audit teams will conduct independent and objective assessments of plan compliance and will establish, monitor and report on any associated corrective action. This rigor and discipline will ensure that we are meeting the state's expectations and those areas where we can improve will be identified and corrected quickly.

Deploying Highly-Qualified, Passionate Staff to Deliver the Nebraska DHHS, Division of Medicaid and Long-Term Care Program

Building and deploying the right staffing model is critical to our ability to meet the operational requirements of the Heritage Health program and deliver on its unique goals and objectives. Our analysis of the RFP and Scope of Work, coupled with the insights gleaned from our statewide campaign, has informed our organizational design and staffing model. Our plan features a large Nebraska-based operation that will be supplemented with corporately-supplied resources. This plan will be fully implemented upon contract award. As we build toward go-live, we will supplement the implementation team with additional resources, consistent with our hiring/staffing plan outlined. For example, we will

deploy resources to Nebraska to begin staff recruitment and hiring efforts while working closely with MLTC to secure necessary approvals for key staff hires. This deployment of incremental resources is a best practice identified during previous implementations and will ensure our ability to meet implementation timelines and expectations. As described in the plan, we expect to be fully staffed well before go-live. **Figure 4** provides an overview of the team that will lead the implementation of the State of Nebraska contract. It summaries their respective primary work assigned and reporting relationships.

Figure 4

Team Leadership Title	Full Name	Primary Work Assigned	Reporting Relationship
Chief Executive Officer	Lauralie M. Rubel	Lauralie Rubel is currently a state president for WellCare and will serve as the interim leader for Nebraska. In this capacity, Ms. Rubel will provide overall direction and prioritization for the MCO; develop and execute leadership strategies, ensure contractual requirements are followed, provide operational oversight and implement integration models ensuring coordination with system partners.	Lauralie Rubel reports to Dave Reynolds, SVP, Regional President for the division that includes Nebraska
Chief Operating Officer	William Keena	Mr. Keena is Vice President of Integrated Solutions. He will serve in an interim capacity as COO for Nebraska until a local COO is appointed. In this role, Mr. Keena will manage day-to-day operations of WellCare's Nebraska-based departments and Staff.	William Keena reports directly to Mike Polen, our SVP of Operations.
Medical Director/Chief Medical Officer	Dr. James Howatt	Dr. Howatt will serve as Medical Director for Nebraska on an interim basis until a Nebraska-based Medical Director is appointed. In this capacity, he will develop, implement and interpret medical policies and procedures; administer the Nebraska medical management activities; participate at Quality meetings with MLTC and lead the UM, QA, Credentialing, Performance Improvement and Provider Advisory committees.	Dr. Howatt reports to Lauralie Rubel, our interim Nebraska CEO
Behavioral Health Clinical Director	Dr. Michael Orlosky	Dr. Orlosky is WellCare's Vice President of Behavioral Health, and will serve as Nebraska's Behavioral Health Clinical Director until a local incumbent is identified. In this capacity, he will be responsible for all behavioral health activities within Nebraska,	Dr. Orlosky reports to Michael Radu, SVP Clinical Operations and Business Development.

Team Leadership Title	Full Name	Primary Work Assigned	Reporting Relationship
Member Services Manager	Paul Hineman	Paul Hineman is VP Channel Communications for WellCare and will serve as Nebraska's interim Member Services Manager until a local incumbent is identified. In this capacity he will be responsible for coordinating communications between WellCare Nebraska and its members, and ensuring there are ample member services representatives available to serve our members' robust needs.	Paul Hineman reports to Mike Polen, SVP Operations.
Provider Services Manager	Drew Hobby	Drew Hobby is VP Business Development. Mr. Hobby's previous role at WellCare was VP Field Network Management. He will serve as interim Provider Services Manager until a local incumbent is identified. In this capacity, he will coordinate communications between WellCare Nebraska and our subcontracted providers.	Drew Hobby reports to Troy Hildreth, VP Business Development Strategy. In his interim capacity, Drew will co-report to Lauralie Rubel, interim Nebraska CEO.
Information Management and Systems Director	Bob Klopotek	Bob Klopotek is VP Information Systems and will serve in an interim basis as Information Management & Systems Director for the Nebraska Market until a local incumbent is identified. In this capacity, he will oversee all of the information systems functions for the Nebraska Market	Bob Klopotek reports to Mike Polen, SVP Operations.
Quality Management Coordinator	Dr. Rich Petrucci	Dr. Rich Petrucci is VP Population Outcomes for WellCare, a function which has enterprise-wide responsibility for Quality. Dr. Petrucci will serve in an interim capacity as Quality Management Coordinator for Nebraska until a local incumbent is identified. In this role, he will be responsible for quality management and improvement for the Nebraska contract.	Dr. Petrucci reports to Michael Radu, SVP Clinical Operations and Business Development.
Case Management Administrator	Lelis Welch	Lelis (Marcia) Welch is VP Clinical Services for WellCare. She will serve in an interim capacity as Case Management Administrator for Nebraska until a local incumbent is identified and will, in this capacity, oversee case management functions for the market.	Lelis Welch reports to Merrill Hausenfluck, COO Clinical Services Organization.
Pharmacist/Pharmacy Director	Laura Hungiville	Laura Hungiville is Chief Pharmacy Officer for WellCare. She will serve as interim Pharmacy Director for Nebraska until a local incumbent is identified. In	Laura Hungiville reports to Michael Radu, SVP Clinical Operations and Business Development.

Team Leadership Title	Full Name	Primary Work Assigned	Reporting Relationship
		this capacity, she will oversee the prescription drug and pharmacy benefits for Nebraska.	
Chief Financial Officer	Jojo Young	Jojo Young is Vice President, Health Plan Finance for WellCare. He will serve as an interim CFO for Nebraska until a local CFO is appointed. In this capacity, Mr. Young will oversee all financial-related activities implemented by WellCare Nebraska, including audit, accounting systems, financial reporting and budgeting.	Jojo Young reports directly to Drew Asher, Chief Financial Officer.
Program Integrity Officer	Amber Barto	Amber Barto is WellCare's Senior Director, Market Compliance. She will serve as Nebraska's Program Integrity Officer on an interim basis until a local candidate is appointed. In this capacity, she will lover see all activities required by State and Federal rules related to FWA, manage the Special Investigations Unit, review and refer suspected member FWA to MLTC, oversee methods to prevent and detect FWA and erroneous payments.	Amber Barto reports directly to Michael Yount, SVP and Chief Compliance Officer.

Each of the leaders identified has already been engaged in the Nebraska project, and they have had staff members engaged, as well. They have either contributed to strategy development or participated in multiple RFP response creation and or implementation planning. Resumes of the key personnel outlined above are found in **Attachment I_ Key Personnel Resumes.**

LAURALIE M. RUBEL

Career History

WellCare Health Plans, Inc. Tampa, FL

State Plan President (August 2015 to Present)

- Plan leader for WellCare's Medicaid expansion into Iowa, inclusive of member-centered strategy, operational implementation, infrastructure and plan performance.

Vice President, Market Development (February 2015 to August 2015)

- Leads business expansion and new market growth through effective planning, collaboration and efficient stewardship.

Vice President, Business Training (September 2013 – February 2015)

- Executive leadership and accountability for associate training in Operations, Sales, Health Services and Network Management/Provider Relations.

Vice President, Market Initiatives (January 2013 – September 2013)

- Acquisition integration and business development.
- Network and communications liaison between seller, acquired entity and WellCare.
- Onboarding support to new associates.
- Business process assessment and improvement.

Vice President, Provider Strategy (July 2011 – January 2013)

- Development and execution of provider strategy in South Carolina, Kentucky, Louisiana, Georgia and Texas to encompass quality improvement, member and provider satisfaction, new business development, and expansion/re-procurement network strategy.

Market Chief Operating Officer (July 2009 – June 2010)

- Promotion to Market COO over Atlanta and North Georgia, inclusive of P&L management of 325,000 covered Medicaid lives in 53 counties.

Senior Market Director (May 2008 – July 2009)

- Promotion to full P&L responsibility for Atlanta Medicaid and Medicare business segments.
- Responsible for medical cost reduction strategy development and implementation.
- Network development, provider relations and compliance.

- SG&A control and policy development for contracting, quality and health improvement initiatives.

UHS – Pruitt Corporation, Atlanta, GA

Vice President of Care Management (October 2010 – July 2011)

- Executive leadership of centralized care management, including intake, concurrent review and continuum of care for more than 125 hospice, home health, skilled nursing and post-acute care facilities and offices across the Southeastern U.S.
- Negotiation and management of payer agreements and relationships, inclusive of billing integration and internal/external payer education.

Regional Director, Payer Relations (June 2010 – October 2010)

Humana, Atlanta, GA

Director of Market Operations, Southeast (January 2005 – December 2005)

Covenant Health – Cariten Senior Health and PHP TennCare

Director of Government Programs (2003 - 2004)

Director of Medicare (2001 - 2004)

Provider Relations Manager (1998 – 2001)

Provider Relations Representative (1995 – 1998)

Foundation Coordinator (1994 – 1995)

Academic Background

University of Tennessee at Knoxville & Tusculum College

- Bachelor of Science in Organizational Management

References

Dora Wilson, COO, Molina Healthcare of South Carolina

- Phone: 843-740-1780
- Address: 4105 Faber Place; North Charleston, SC 26405

Patrick Devlin, VP of Talent, Evolent Health

- Phone: 571-385-3889
- Address: 800 North Glebe Road, Suite 500; Arlington, VA 22203

Courtney Pearre, VP, Government Relations, Amerigroup Tennessee

- Phone: 615-717-7990

Address: 22 Century Boulevard, Suite 310; Nashville, TN 37214

WILLIAM KEENA

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Integrated Solutions (September 2015 – Present)

- Executive leader accountable for oversight and execution of acquisition integration activities. Serves as a trusted resource in business planning, organizational planning, financial performance and initiatives related to integration activities. Role may provide interim executive leadership for new growth or acquired businesses until permanent leadership is established.

Acclaris, Tampa, FL

Chief Operating Officer (July 2013 – June 2015)

- Led the transformation of the company operations that prepared the company for a strategic acquisition at triple the company's prior value which occurred in May of 2015.
- Stabilized and improved company operations enabling scalability, client growth and transformation to a consumerism model.
- Improved turnaround times of processes such as customer inquiry tickets by more than 30%. Increased overall corporate productivity by 34% by reducing costs and improving quality (To over 99.5% Financial).
- Increased Client loyalty (Net Promoter Score) from -48 to +3.2 during this time. Led company Operations and Information Technology areas across all six US and India locations. Responsible for service and relationships with all clients including Bank of America, Fidelity Investments, Xerox and Highmark Blue Cross/Blue Shield. Led the redesign and replacement of the data center hardware and network, from data storage to the fax servers. Personally oversaw each phase of the project and migration to the new infrastructure.
- P & L responsibility on 10% of the corporate revenue in the business process outsourcing line of business, personally sold $520,000 in new business (23% growth) in 2014 with excellent (>50%) margins.

VALA Consulting/CACI

Independent Consultant (July 2008 – June 2013)

- Created and operated an independent consulting business. The largest opportunity was at CACI, a contractor to the US military. While at CACI ran a key program and grew it from 4.18 million in annual revenue to over 17 million.
- Led multiple software development teams across six sites with 155 direct reports. Projects included creating a ground up next generation supply/logistics system for the US Navy and Marines (Single Supply Baseline) using open source tools.

- Functional lead and Subject Matter Expert on a suite of projects to upgrade the systems and processes at a California based Medicaid/Medicare Health plan.

AMERIGROUP Corporation Virginia Beach, VA

Executive Vice President, Support Operations (May 2006 – June 2008)

- Spearheaded the turnaround of Operations to ensure that significant compliance and encounter submission issues were addressed while simultaneously managing significant growth (700,000 new members) and a system conversion.
- Reduced IBNR (Incurred but not reserved) exposure by 99.9% for prior periods.
- Eliminated backlog and restored DOI (Department of Insurance) compliance in key states such as Texas. These efforts increased the stock price from $17 to $34 in less than two years. Led the claims, encounters, front end operations, credentialing, contract configuration and three National Service Centers (Virginia, Florida and Tennessee), plus the Clinical Call Center (Provider services area), and other Operations departments.
- Budget of over 100M, 1500+ associates.
- Member of the Executive Team.

Academic Background

University of Connecticut
- Bachelor of Arts, Magna Cum Laude

References

Tony Pino, Senior Vice President
- Phone: 443-769-7609
- Address: 300 E. Lombard St., #1610; Baltimore, MD 21202

Bebe Agnew - Bezzeg, Senior Director, Coventry Workers Comp Services
- Phone: 813-421-8575
- Address: 5130 Eisenhower Blvd S. #3; Tampa, FL 33634

Donald Fowler, Vice President, HighMark
- Phone: 412-544-1531
- Address: P.O. Box 226; Pittsburgh, PA 15222

JAMES HOWATT, MD, MBA

Career History

WellCare Health Plans, Inc. Tampa, FL

Medical Director (October 2015 - Present)

- Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations.
- Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease management activities, quality improvement activities, and provider relations functions.

Heritage Provider Network, Inc. Los Angeles, CA

Private Consulting (June 2014 – October 2015)

- Assigned to dual eligible demonstration implementation, CMO Cumberland Health Analytics, Guidepoint Global advisors and Pharmacy advisory boards.

WellPoint/Anthem/CareMore/Amerigroup Indianapolis, IN

Staff Vice President, Medical Director (2011 – 2014)

- Assigned to the Corporate Duals Team, responsible for winning and implementing Duals Demonstration projects. Participated in winning presentations to CA, VA and NY.

Senior Medical Officer (2012 – 2013)

- Dedicated to developing and implementing the Model of Care for CareMore participation in Dual Eligible Demonstrations.

Staff Vice President State Sponsored Business (Medicaid) Care Management (2011 – 2012)

- Responsible for oversight and management of Medical Directors and collaborative structure and management of over 1.8 million Medicaid beneficiaries in 10 states. Duties include Utilization Management, Quality Management and clinical input into member and provider management strategies.

Molina Healthcare Long Beach, CA

Chief Medical Officer Medicaid Services (2010 – 2011)

- Designed and promoted innovative products expanding the role of MMIS and Fiscal Agent services for state Medicaid programs.

Executive Vice President, Corporate Chief Medical Officer (2007 – 2010)

- Responsible for representing Medical Affairs in cross-functional committees driving strategy for national contracting and network management. Oversight responsibility for risk adjustment score strategies.

Chief Medical Officer (2006 – 2007)

- Helped organize integrated healthcare model which won national recognition (Washington Medicaid Integration Partnership).

Academic Background

University of California, San Francisco
- Doctorate Degree

University of Phoenix
- Master's Degree, MBA

References

Thomas Wilfong, Anthem
- Phone: 757-490-6900
- Address: 4425 Corporation Lane, Suite 100; Virginia Beach, VA 23462

Michael Siegel, MD, Molina Healthcare
- Phone: 562-435-3666
- Address: 1 Golden Shore, Long Beach; CA 90802

Mark Kiffer, DO, Humana
- Phone: 480-515-6400
- Address: 20860 N Tatum Blvd, Suite 400; Phoenix, AZ 85050

MICHAEL J. ORLOSKY, M.D., M.M.M., C.P.E.

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Behavioral Health (2014 to Present)

- Responsible for all WellCare markets for the performance of Behavioral Health operations including medical expense, quality, and provider management.
- Developed curriculum for Integrated Care Management training.
- Provided direction and design for on-boarding training for all clinical staff for WellCare.
- Developed Behavioral Health model of care for the enterprise.

Senior Medical Director, Florida Market (2013 - 2014)

- Assisted with the Managed Medical Assistance Intent to Negotiate presentations to AHCA, with WellCare winning 8 of 11 Florida regions.
- Created clinical model and program strategy for Patient-Centered Medical Homes.
- Facilitated the development of a Behavioral Health PCMH with Lakeside and a shared savings pharmacy program.
- Established relationships with key provider groups and facilities.

Health New England

Medical Director (2011 - 2013)

- Responsible for the medical and case management activities related to managed medical operations for Commercial, Medicaid, and Medicare lines of business.
- Served as Medical Director for HNE's Medicare Advantage line of business, which was awarded 5 STAR status by CMS in 2012 and 2013.
- HNE's Commercial HMO ranked 11th Nationally by NCQA.
- HNE's Medicare Advantage program ranked 26th Nationally by NCQA.
- Responsible for implementing Risk Adjustment program for HNE's Medicare Advantage Beneficiaries.
- Assisted with CMS Best Practice Review with HNE Management.
- Speaker at various Medicare Advantage conferences related to achieving 5 STAR status.
- Developed and implemented Patient-Centered Medical Homes.
- Developed and implemented Bundled Payment programs for orthopedic procedures.
- Served on the Board of Directors for Massachusetts Health Quality Partners.
- Headed the Medical Technology Assessment Committee (MTAC) for HNE.
- Interface with physician providers to create new systems of health care delivery (ACO and Full Risk PCMHs).

ValueOptions North Carolina Service Center

Interim Medical Director (2010 - 2011)

- Served as interim medical director for North Carolina office performing utilization review activities and supervision of clinical staff.

Human Capital Specialists

Executive Vice President and Chief Operating Officer (2009 - 2010)

- Responsible for the development and implementation of consulting services for Human Capital Specialists with focus on health care opportunities that offer:
  - Improved quality and operational results
  - Six sigma strategies for process improvements
  - Financial turnaround
  - Change management
  - Expert training, information, and implementation skills
- Led the integration of 8,000,000 behavioral health covered lives for a large, multi-state Blue Cross Blue Shield Health Plan.

WellPoint, Inc., North Haven, CT

East Regional Vice President of Behavioral Operations (2006 - 2009)
Executive Medical Director, Northeast Division (2003 – 2006)

- Drove the operational performance of the 7th, 16th, and 20th nationally ranked Health Plans as published in US News and World Report (2008).
- Led the expansion of Behavioral Health Operations from a single state (CT) and 23 staff, to a regional operation with 7.6 million enrollees in Connecticut, Maine, New Hampshire, New York, Virginia, and Georgia.
- Managed and led the reorganization of 160 Associates in three offices (Atlanta, Richmond, and North Haven), with an annual operating budget of over $95 million and revenue of $600 million.
- Delivered operating gain that exceeded budget every year.
- Improved associate engagement and manager effectiveness measures to Best in Class levels.
- Succeeded at full accreditation from URAC and NCQA and created a HEDIS improvement strategy that was published in a national quality journal.

Clinical Experience

Medical Director, 5SB Unit, Mercy F. Hospital, Darby, PA (1998 – 1999)

- Lead several multidisciplinary teams to re-engineer the treatment process of seriously mentally ill patients in an intensive, managed-care environment.
- Established and monitored quality outcomes through the institution of control charts and data measurements.

- Developed programs with Delaware County Mental Health to address the displacement of psychiatric patients due to the closing of Haverford State Hospital.

Director, Apogee, Inc., King of Prussia, PA (1996 – 1998)

- Served as Director of Comprehensive Mental Health Services. Member of Northeast Regional Directors. Served on Apogee's National Committee of Clinical Quality. Responsible for Budgeting and Strategic Planning. Redesigned the Performance Appraisal System for Clinicians in 112 Clinics.

Academic Background

Tulane University's School of Public Health and Tropical Medicine, New Orleans, LA (1998 – 1999)

- M.M.M, Master's Degree in Medical Management

The Waltham Hospital (PGY-1), and Massachusetts General Hospital (PGY-2 through PGY-4), Boston, MA M.M.M, Master's Degree in Medical Management (1978 – 1982)

- Psychiatric Residency

College of Medicine, University of South Florida, Tampa, FL (1975 – 1978)

- Doctor of Medicine (M.D.)

The John's Hopkins University, Baltimore Maryland (1972 – 1975)

- Bachelor of Arts

References

Dr. Steven Korn, Anthem BC/BS

- Phone: 203-677-8069
- Address: 108 Leigus Road; Wallingford, CT 06492

Dr. Seth Feuerstein

- Phone: 203-623-7714
- Address: 657 Orange Center Road; Orange CT 06477

Dr. Donna O'Shea

- Phone: 413-794-7045
- Address: Chestnut Street; Springfield MA 01199

PAUL HINEMAN

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Channel Communication Services (2015 to Present)

- Provide strategic direction, policy, operational planning and execution across all internal/external Customer Service operations. Provide strategic direction, consistency and oversight for member and provider channel communications, including establishing/maintaining positive relations between the Company and its key constituents to advance business objectives.
- Leads teams responsible for collaborating with business partners and executive leadership to drive and enhance the company's business objectives through strategic, compliance-based and transactional communications initiatives across a variety of communications channels.
- Leads the development and implementation of channel communications-related policies and process improvements for realized cost savings and overall volume efficiencies,
- Strategizes, leads and coordinates vendor procurement; manages vendor relationships in relation to maintaining service level agreements for member/provider communication/processing functions.

Nielsen, Oldsmar, FL

Vice President, Florida Operations Leader (2011)

Senior Vice President, US Call Center Operations (2012 – 2015)

- Accountable for the strategic direction of four US based Market Research call centers and two third party vendors internationally consisting of 2,200 part time and full time associates supporting Operations, Training, Quality and Work Force Management departments. Leveraged predictive dialers to initiate over 100MM dials and completed over 6MM surveys and recruitment calls annually.
- Led initial integration for 1.3B Arbitron acquisition representing the Data Acquisition department which consisted of both field and call centers totaling 1,000 impacted employees. Process required consistent collaboration with key business owners and stakeholders including frequent engagement with the COO.
- Integrated six Call Centers and three Lines of Business due to a large acquisition late 2013
- Budgetary savings as a result of the integrations and subsequent consolidation in excess of 15% or 8MM through first 18 months primary through site consolidation and labor efficiencies.
- Led integration efforts on new CATI and Dialer solutions for improved quality and efficiency through improvements in contacts, dialing efficiency and agent usability.

WellCare Health Plans, Inc., Tampa, FL

Vice President, Customer Service Operations (2009 – 2011)

- Provided the strategic direction of internal and external customer service groups that supported multiple products under the Medicare and Medicaid lines of business. Ensured Training, Quality, Productivity, and Compliance standards were met through effective communication, training, and planning.
- Led Customer Service process improvement initiatives focused on new member enrollment and intake activities.
- Drove efforts to enhance the Member's experience at our two Philippines sites through improved on line help tools, training enhancements and use of analytics from 3rd party quality vendor.
- Provided direction to consolidate site locations for Medicare product lines with increased concentration at near shore site in the Dominican Republic with savings of 20%+ for this LOB.
- Coordinated the launch of the customer service function for the newest market, Hawaii.

Senior Director, Customer Service Operations (2008 – 2009)

- Provided strategic direction of external customer service groups that supports multiple product lines under the Medicare line of business.
- Led efforts to enhance and promote usage of an external website for self-service functionality for both Providers and Members with increases over 150% in under 12 months.
- Established process improvement initiatives for call center functions derived from analysis on first call resolution and a third party customer satisfaction survey process.
- Provided support to launch two vendors sites in the Philippines in efforts to reduce costs by as much as 40% for two Medicare product lines.
- Contracted with 3rd party Quality vendor to provide independent quality review to provide analytics on compliance and quality standards.
- Achieved recertification for call center excellence from JD Power in 2008.

Director, Customer Service (2005 – 2008)

- Led the coordination and set up of the customer service function for the new national Medicare Part D product, Prescription Drug Plan, responsible for generating over one billion in revenue by 2008. Successfully managed the launch of five call centers to support this product in under 90 days.
- Established vendor contracts, telecom and IT set up, product training, policies and procedures, and support team for call centers in less than 90 days.
- Achieved 15% reduction in 25MM call center budget over the first 8 months of 2006.
- Improved productivity in the call centers through the implementation of a new User Interface for the call center staff that reduced Average Handle Time by 32% over seven months.
- Implemented a post-call satisfaction survey and maintained 82%+ satisfaction rates since launch of the product.
- Managed numerous on-going and proactive outbound call campaigns to improve customer satisfaction and retention.
- Provided strategic direction and oversight for the customer service function for both Medicare and Medicaid product lines within an internal and outsourced environment.
- Achieved JD Power certification for call center excellence in 2007.

Academic Background

Palm Beach Atlantic University

- Bachelor of Science, Business Administration

References

John Eagle, President, Internal Audit – FIS

- Phone: 727-227-5129
- Address: 11601 Roosevelt Blvd; St. Petersburg, FL 33716

Tamela Puckett, Senior Human Resources Business Partner, Nielsen

- Phone: 813-366-3012
- Address: 501 Brooker Creek Blvd; Oldsmar, FL 34677

John Streitmatter, Director, Leadership Research Institute

- Phone: 813-785-2633
- Address: 499 Cove Drive; Palm Harbor, FL 34685

DREW HOBBY

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Business Development (April 2015 – Present)

Vice President, Field Network Management (March 2014 – April 2015)

- Lead organization responsible for hospital contracting, physician contracting, risk provider contracting, provider relations, behavioral health and provider solutions across the state of Florida.
- Responsible for development and execution of organization's network contracting and management strategy.
- Partner with internal resources to analyze cost data, medical trends, and quality results to deliver network that meets strategic priorities of market.
- Provide strategic negotiation assistance to team specifically around rate evaluation and contractual language. Constantly monitor regulatory landscape, proactively evaluate contractual feasibility, and partner with other departments (legal, government affairs, configuration, finance, and legal) to ensure ability to implement accordingly.

Senior Director, Product Operations – Florida Healthy Kids (January 2012 – March 2014)

- Responsible for P&L ownership of WellCare's Florida Healthy Kids (SCHIP) product.
- Led the program design, RFP response, and negotiations of statewide RFP.
- Obtained largest award and successfully expanded county footprint from 18 to 65 (out of 67) counties.
- Expanded top line revenue by over 30% in year one.
- Led the successful implementation of a large scale roll-out across 48 counties with varying degrees of experience with managed care.
- Led WellCare of Florida's Exchange offering including network build and other strategic product offering components.

Senior Director, Medicaid Expansion (April 2011 – January 2012)

- Identified, pursued, and won new Medicaid business for the organization
- Worked with existing market leaders or business development team to understand local regulator's Medicaid program needs, design WellCare's response, and help lead response to RFI/RFP requests

KPMG, LLP

Senior Manager/Director, Advisory (March 2003 – March 2006; August 2007 - March 2011)

- Service Line Leadership – Led the "North Florida" service line (Tampa, Orlando, and Jacksonville) for Information Risk Management within external audit clients. Led team responsible for managing over 500 engagements per year
- Revenue Generation and Management – Responsible for selling advisory services (through new client generation, revenue expansion, and new service offerings) throughout Tampa/Orlando/Jacksonville, the Southeast, and HealthCare and Technology companies across the United States
- Engagement Management – Responsible for managing multi-million dollar engagements at 15 to 20 clients per year. Ultimate engagement management responsibility including delivery of contracted services, ensuring client satisfaction, execution within approved budgets, and project quality
- Industry Focus – Primary focus within the healthcare (providers and payors) and technology (software, hardware, IT services, technology distribution, and IT staffing augmentation) industries

WellCare Health Plans, Tampa, FL

Finance Corporate Development Manager (March 2006 – July 2007)

- Served as finance corporate development manager for one of the leading providers of government sponsored health plans. Responsible for the successful delivery of strategic and cross-functional projects in role as lead project manager on strategic projects for Chief Financial Officer.

JDH Consulting

Independent Consultant (November 2001 – February 2003)

- Provided customer service consulting services to Fortune 1000 companies. Scope of engagements included review of insourcing/outsourcing model, operating model re-design, and process improvement opportunities within call center arena. Re-designed call script process for leading handheld technology company that resulted in multi-million dollar savings (annualized).

Intel Corporation

Business Analyst (June 2000 – October 2001)

- Performed analysis of Intel's financial processes as well as the computer systems used to support accounting and finance functions. Responsible for the review of business requirements and the configuration of systems around respective processes. Conduit between programmer analysts and management in the design and day-to-day operations of financial software and systems.

Academic Background

Indiana University
- Bachelor of Science, Business Process Management

References

Timothy J. Gibson. Regional Director, Payer Strategy and Product Development, Trinity Health
- Phone: 515-643-7418
- Address: 1755 59th Place; West Des Moines, IA 50266

Jason Humphrey, Senior Director, Payer Strategy and Contract Management, CHI
- Phone: 515-643-7417
- Address: 1111 6Th Avenue; Des Moines, IA 50314

Josh Kevan, Principal, Sr. Consultant
- Phone: 503-221-4200
- Address: 1211 SW 5th Ave, Suite 900; Portland, OR 97204

ROBERT D. KLOPOTEK

Career History

WellCare Health Plans, Inc., Tampa, FL

Vice President, Information Systems (October 2005 – Present)

- Initial accountability (and successful launch) for all IT aspects of WellCare's national PDP plan, providing solutions for both internal and government partner challenges.
- Assumed responsibility for stabilizing Medicaid enrollment processes for 3 new, large Medicaid plans.
- Successfully led the design, development, and implementation of enterprise-wide Enrollment intake and Correspondence Tracking capabilities supporting both Medicaid and Medicare.
- Corporate Accountability for conducting Regulatory Steering Committee to ensure timely and accurate transition of regulatory changes to system solutions. Includes oversight and delivery for associated projects, ranging from annual AEP and CMS releases to Medicaid Reporting and NPI deployment.
- Assumed responsibility for a large collection of home-grown, surround applications in Delphi. Reduced operating costs and improved productivity by documenting requirements, retiring several applications by eliminating redundancy, and migrating to C#/Oracle during major system upgrade.
- Accountable for all aspects of Core Platform application support. Accomplishments include stabilizing platform and eliminating outages, successfully completing two major upgrades during 3-day weekends without business disruption, and successfully negotiating long-term vendor contract that provides dedicated vendor staff and long-term platform stability at a very affordable cost per member.
- Responsible for primary interactions with operational and product development business units. Approach became the model for the corporate IT Single Point of Contact (SPOC) process.
- Assumed responsibility for operations area and transformed the focus "from IT Operations to Production Control". Includes negotiation, monitoring, and delivery of business-meaningful SLAs as well as 24x7 monitoring of business operations and functions, with playbooks and escalation procedures to ensure effective business outcomes.
- Continually maintain focus on recruitment and staffing activities, placing emphasis on balanced, honest feedback that provides actionable improvement and growth information, a recruitment process that brings in only quality additions, and continuous knowledge transition. Demonstrated through 5 years as IT instructor for internal "Essentials of Managed Care" program, serving as advisor to USF Graduate Student program (2012) student project, and high annual Associate Opinion Survey scores.
- Transitioned to accountability as Chief Architect of WellCare (2014), accountable for Enterprise Architecture and management of Solution Architects to ensure development of robust, scalable applications in support of our government partners.

Amisys Synertech, Inc., Harrisburg, PA

Vice President, Product Engineering (ASI) (October 2003 – October 2005)

- Reporting to CTO, responsible for activities of all software development staff of >70 FTEs and contractors. Primary activities were the successful development and support, in an ASP arrangement, of CDH solutions for 3 early entrants (Lumenos, Definity, HMI) in a 6 month period as well as the migration of the AMISYS application from proprietary HP 3000 to Java/Oracle platform. Both solutions continue to be utilized and generate revenue.
- Continued maintenance and support for all ASP products and solutions, including "HSII", "QMACS", "Pathways Managed Care" platforms and application code.
- Technology platforms supported included MUMPS, Visual Basic/.Net and SQL Server, C++ and Sybase, COBOL and Turbo Image (HP3000), Java/J2EE and Oracle, and web technologies such as JSP, HTML, and Struts Framework.
- Led development and implementation of process improvement and BPM solutions utilizing Microsoft BizTalk to improve claims processing productivity and reduce operational costs.

Chief Information Officer (March 2001 – October 2003)

- Successfully provided and managed all infrastructure and IT components of ASP business operations, running multiple server platforms and operating systems (Compaq Proliant/Windows and HP/HP-UX; also Linux, Sun/Solaris, and HP 3000). Exceeded contractual 99.5% availability standards with actual average of >99.9%.
- Accountable for budget, availability, vendor selection and management functions of delivering seamless implementation and support for all infrastructure components, ranging from network and telecom (internal network, dial up, frame relay, and wireless internet), connectivity (including Citrix and VPN), security (Intrusion Detection, Firewalls, Virus scanning) and data center facilities.
- Led and managed 24x7x365 operations area responsible for tens-of-thousands of weekly job process and file transmission activities. Implemented and met business-driven SLAs for these operations.
- Responsible for all Business Process Outsourcing and Software Development Functions in Pick/Unidata, MUMPS, Oracle and SQL Server along with Lotus Domino, Sybase, and Turbo Image.
- Responsible for IT Policy and Governance including topics such as IT Security and Password, HIPAA, and Change Management policies and leadership and oversight of Corporate Technology Committee.
- Accountable for development, annual testing, and revision of Data Center recovery plan, demonstrating the ability to meet the contractually-obligated 72 hour recovery time objective.
- Led service desk area for >1000 internal users and >2000 external users supporting all application and infrastructure services, managing to aggressive response time and resolution SLAs.

Director, Managed Care Software Development (1996-2001)

- Oversight of software development and maintenance for flagship software offerings. Accountable for budget and delivery obligations of >50 FTEs and contractors supporting

multiple software solutions ("HSII", "QMACS", and "Tingley) and corresponding custom software on multiple technology platforms (including MUMPS, Visual Basic/.Net and SQL Server, Java and Oracle).
- Successfully led the development and implementation of Medicare Part C solutions for new and existing clients in 9 months, including all CMS transactions and formats.
- Supported the Advanced Systems group charged with migrating MUMPS application and code generation tools to object-oriented, Java-based solution.
- Successfully developed and executed skills transition plan of MUMPS and Pick developers to newer technologies, including VB, SQL Server, and object-oriented approaches.
- Leadership and responsibility for EDI and clearinghouse interactions and data file mapping (including HIPAA Transactions) utilizing BizTalk, EZ-Map, and Mercator.

Manager, Software Development (1992-1996)

- Design and Management responsibilities for specified application modules, including new development and maintenance, with accountability for >20 FTEs and contractors.
- Through various restructurings, assumed responsibility for development teams supporting all application modules, including systems and tools functions, improving system design and cohesion.
- Designed, led, and helped develop "Pre-enrollment" module to support individual and Medicaid Market in 3 months, expanding customer market opportunity and reducing operational expense.
- Designed and developed a provider Capitation module that included Fully-Capitated and Episode-of-Care based reimbursement and risk sharing solution in 6 months.

Academic Background

St. Norbert College, DePere, WI
- B.B.A. Accounting with Minor in Computer Science

References

Jim Boyles, President, The Partners of Integrity
- Phone: 717-903-9277
- Address: 437 Woodruff Way; Harrisburg, PA 17112

Louis (Mick) Meckler, President
- Phone: 717-421-1723
- Address: 3824 Chippenham Road; Mechanicsburg, PA 17050

Gina Orellans
- Phone: 813-230-8464
- Address: 16919 Candaleda de Avila; Tampa, FL 33613

RICHARD PETRUCCI, M.D.

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Population Outcomes (February 2015 – Present)

- Provides leadership, develops strategies, coordinates work streams and methodically implements enhancements to the Care Model to enable WellCare members to receive the "Right Care" at the "Right Time" in the Right Place."
- The role develops strategies, coordinates activities, drives objectives and achieves business goals by interacting at 4 points of contact:
    - Interaction with the CMO (Chief Medical Officer) and direct reports of the CMO;
    - Interaction with Market Presidents;
    - Interaction with members of the SMT (Senior Management Team);
    - Has line responsibility for the CSO (Clinical Services Organization) "Population Health & Quality staff.

New York State Medical Director (January 2013 – February 2015)

- Leader of New York Quality Improvement Team, responsible for the State specific Medicare STAR and Medicaid Quality (QARR) measure results.
- Leads QI team in root cause/barrier analysis of individual results by Line of Business (LOB), designs interventions to address barriers and implements program to improve quality scores. Leader Field-Based Case Management Team provided Clinical Leadership for Field-based team that meets Face-to-Face with members & their families/support systems, that attends Member Physician appointments post-hospital discharge & that coordinates all Care Services including social service, transportation, housing, etc.
- Clinical Lead for development of the Regional Dashboard and IPA management strategy analysis used to improve IPA performance.
- Clinical Lead for Corporate Telephonic Case Management and Disease Management Team – Redesigned disease specific assessment, workflows and interventions.
- Redesigned program metrics to align focus on improving HEDIS results, reducing hospital re-admissions, reducing preventable admission and improving medication adherence to improve overall Medicare STAR and Medicaid Quality sores.

MannKind Corporation, Valencia, CA

Vice President, Medical Affairs (April 2008 – January 2013)

Leader AFREZZA (Technosphere insulin) Product Development and New Drug Application (NDA) Team:

- Clinical Lead for all clinical interactions with FDA:

  - Clinical Lead for Type C meeting with FDA held in August 2011 – defended new MannKind Phase 3 Clinical Trials designs and successfully negotiated final design agreed upon with FDA creating a clear path forward for product approval
  - Clinical Lead at second End of Review meeting with FDA held in May 2011 – defended and negotiated design and implementation of new clinical trials needed to satisfy the second Complete Response Letter (CRL) from FDA received January 2011.
  - Member of 8 person team for first End of Review meeting with FDA. Represented MannKind at the End of Review meeting with the FDA and addressed the concerns regarding the efficacy of AFREZZA with the members of the FDA's team.
- Clinical Lead for AFREZZA Clinical Trial Program:
  - Responsible for the development, implementation and execution of new Phase 3 clinical trial program required to satisfy the FDA requirements outlined in the CRL.
- Clinical Lead responsible for filing of NDA:
  - Leader of the 5 person Integrated Summary of Efficacy (ISE) Writing Team which was responsible for developing the strategy on how to present the efficacy data and for executing on the production of the ISE document in a timely manner to meet the regulatory requirements to demonstrate product efficacy.

Head - Biostatistics and Data Management Group:

- Clinical Head of BioMetrics Team that was responsible for the selection, implementation and analysis of all hardware and software tools needed for the execution of the clinical trial program and submission of the AFREZZA NDA.
- Responsible for department of 6 FTE statisticians and SAS programmers.

Clinical Lead - AFREZZA Product Commercialization Team:

- Medical lead on product partnership team – responsible for efficacy presentations and review of all efficacy materials and data with potential business partners.
- Key Opinion Leader (KOL) advisory Board activities – partnered with Commercial Team to set agendas, create presentations, present data and provide KOL feedback to the company
- Active member of the Pricing and Reimbursement team
- Assists Commercial Team with the development of market research tools for patients, physicians and payers.

Head - Scientific Publications:

- Manager of 3 person team responsible for all company-wide publications including abstracts and manuscripts. In 2009, team was responsible for presenting 12 abstracts and 2 oral presentations at the annual ADA meeting as well as 14 at the EASD meeting and the publication of 3 manuscripts. In 2010, team had 10 abstracts and 3 oral presentation accepted. In addition, several manuscripts have been submitted for publications including one which has been accepted by the Lancet for publication in June 2010.

Senior Director, Diabetes Clinical Research and Development (April 2007 – April 2008)

- Responsible for the generation of all scientific publications for MannKind's products – this included the generation of all abstracts for publication at national/worldwide conferences such as the ADA and EASD meetings as well as the full manuscript publication in journals such as Diabetes Care and Diabetoligica.
- Responsible for the creation of CME programs in the area of diabetes care with particular focus on the importance and use of prandial insulins in Type 2 Diabetes.
- Responsible for the development, the management and oversight of all Key Opinion Leader advisory boards – focused in the areas of Endocrinology, Pulmonology and Primary Care Medicine. Worked with the Medical Writing and Commercial Brand Teams in the development of MannKind's diabetes advisory boards and plays an active role in their execution.

Academic Background

Albert Einstein College of Medicine, Bronx, NY
- Rheumatology Fellowship

North Shore University Hospital, Manhasset, NY
- Internal Medicine Residency

New York Medical College, Valhalla, NY
- Doctor of Medicine

Williams College, Williamstown, MA
- B.A., Biology

References

Dr. Marc Tack, DO
- Phone: 845-338-7140
- Address: 360 Washington Ave; Kingston, NY 12401

Dr. Deepak Patel, MD
- Phone: 845-339-5100
- Address: 518 Broadway; Kingston, NY 12401

Dr. Maria David, MD
- Phone: 845-565-5437
- Address: 266 North St.; Newburgh, NY 12550

MARCIA LELIS WELCH, RN, BSN, CCM

Career History

WellCare Health Plans, Inc., Tampa, FL

Vice President, Clinical Services (April 2014 – Present)

- Directs the plan's health services function which may include pre-authorization, concurrent review, complex case management, quality improvement, credentialing, health and wellness and disease management.
- Oversight of the overall coordination, implementation and monitoring of activities to yield quality driven, compliant, efficient and cost-effective results.

Aetna/CoventryCares of Kentucky, Louisville, KY

Vice President, Health Services (August 2012 – April 2014)

- Direct report to the Chief Medical Officer to meet targets for inpatient bed days, meeting Medical Loss Ratio targets and increasing quality of care for members, developing and adhering to the budget for the Health Services Department and oversight of the corporate case management programs, and for developing programs specific to the needs of the Kentucky population.

Select Health of South Carolina, Charleston, SC

Regional Clinical Lead for the Southern Region (February 2012 – August 2012)

- The parent company, AmeriHealth Mercy, expanded into additional states creating the need to expand the scope of the then current clinical lead position in South Carolina. Responsible for oversight and development of the Utilization Management, Case Management, Maternal Child Case Management, Rapid Response Unit and the Appeals Department for all 3 states, including developing the budget for all three states. A total of 380,000 Medicaid/SCHIP members were managed between the plans.

Senior Director, Medical Services (September 2008 – February 2012)

- Responsible for designing and implementing policies and procedures for our UM, CM and DM departments, which contributed to their obtaining their initial NCQA accreditation, budgetary oversight, monitoring of under and over utilization and development of productivity standards. Areas of responsibility included Case Management, Disease Management, Maternal Child Case Management, Utilization Management, Provider Appeals and Delegated Onsite activities for external vendors for Behavioral Health and High Tech Imaging for a 170,000 member Medicaid Program, in addition to managing the new SCHIP membership in South Carolina.

Health Integrated, Tampa, Florida

Senior Director, Behavioral Health Utilization Management and Case Management (January 2008 - June 2008)

- Areas of responsibility included Behavioral Health Utilization Management and Case Management for a combination of Commercial, Medicaid and Medicare Advantage members.

BlueCross BlueShield of Tennessee, Chattanooga, TN

Director/Senior Manager for Medical Management (October 2006 – November 2007)

- Responsible for the continued development of the Medicaid (BlueCare) line of business for 600,000 members; development of the Medical Management platform for the newly assigned SCHIP members; and the development of two commercial products to offer to Tennessee's low-income uninsured and the uninsurable populations (Cover Tennessee).

- Senior Managers and Managers over Utilization Management, Disease Management, Case Management, Care Coordination, Member Outreach, Member Appeals, Provider Appeals, Retrospective and Pre-existing Reviews, Systems and Education, and the Senior Manager who coordinated Behavioral Health Services with the State's Behavioral Health Organization reported to this position. Responsible for developing the budgets for all 4 lines of business for the Medical Management areas.

Senior Manager, Commercial Medical Management Division (2005 – 2006)

- Responsible for oversight and continued development of the Utilization Management, Case Management, Catastrophic Case Management, Care Coordination, Transplant Case Management, High Risk OB Case Management areas, including managing the Federal Employees (FEP) medical management department, for a total of 1.6 million lives. Responsible for the budget for this department's Medical Management Division and meeting medical management targets.

- Three highlights during this period were our department's development of a DVT prevention program, an end-stage support program (HOPE), which focused on Hospice, Oncology, Palliative Care and End State Disease, and participation in the design, development and implementation of Custom Care Solutions, a programmed designed to meet the needs of one of our large municipal accounts with high cost members to reward members for participation in the case management program, with a focus on referring members to best-practice practitioners.

Senior Manager, Medical Management (1999-2005)

- During this period all of the medical management departments at BlueCross Blue Shield of Tennessee were combined into one department, with management being divided into East

and West. This position was responsible for providing direction and management for the eastern part of Tennessee, which included Commercial and Medicaid lines of business. In addition, the Eastern Division managed Security Blue, an HMO Medicare Product which was just available to members residing in one geographical section of the eastern part of the state. 1.4 million lives were managed for the eastern part of the state.

Manager, Clinical Services, Medicaid Division (1997 – 1999)

- Manager for all of the medical management staff who worked in the areas of Utilization Management, Case Management, Provider Appeals, Member Outreach, and Demand Management (our internal 24/7 Nurse Line) for a membership of 600,000. During 1996/1997 the Case Management and Demand Management departments were created for the Medicaid population. The Utilization Management function for Medicaid was transitioned from the Commercial side.

Academic Background

Jacksonville University, Jacksonville, FL
- B.S., Nursing

Cleveland State Community College, Cleveland, TN
- A.S., Business Administration
- A.S., Nursing

References

Karin Ferguson, QI Corporate VP, AmeriGroup
- Phone: 804-304-3388
- Address: 7365 Prairie Road; Richmond, VA 23225

Fred Volkman, MD
- Phone: 843-697-5589
- Address: 5407 Henrietta Hartford Road; Mount Pleasant, SC 29466

Peggy Vickery, Director of Provider Relations, Select Health
- Phone: 843-270-0286
- Address: 233 Tall Sail Drive, E.; Charleston, SC 29414

LAURA HUNGIVILLE

Career History

WellCare Health Plans, Inc., Tampa, FL

Chief Pharmacy Officer (April 2013 – Present)

Vice President, Pharmacy Services (August 2013 – April 2013)

Vice President and General Manager PDP and Specialty Pharmacy (February 2010 – August 2013)

Vice President of Pharmacy (April 2008 – February 2010)

Vice President of Pharmacy Operations (July 2006 – April 2008)

- Responsible for execution of the pharmacy benefit for all lines of business including claims payment, formulary development and implementation, network contracting, rebate negotiation, provider outreach, quality, regulatory reporting, compliance, medical expense management, PBM Selection and oversight, medication therapy management, call center operations, prior authorization processing, benefit design, encounter submission, specialty pharmacy operations, Mail Order pharmacy operations, Over-the-Counter program, direct member reimbursement, residency program and student rotations.
- Manage $7.5 Billion in Annual drug spend.
- P&L Responsibility for standalone PDP product.
- Consistent industry leading cost management of pharmacy benefit across many lines of business.
- Created product that led to growth of 40% and responsible for over 20% of company's earnings.
- Designed and implemented industry leading Medication Therapy Management program, recognized by CMS to decrease health care costs.

Director/Senior Director, Pharmacy Operations (March 2004 – July 2006)

- Evaluate, develop business strategy and launch WellCare's Part D program.
- Develop formulary, model costs, pharmacy operational requirements, benefit design.
- Oversight of implementation of the new product.
- Manage pharmacy operations including staffing, process improvement, quality initiatives.

Eckerd Drug Company Largo, FL

Clinical Operations Manager (2001 – 2004)

- Manage 24 Clinical Pharmacists in six states.

- Generate revenue for services, marketing of product and expense management.
- Integrate clinical services into the dispensing role.

Patient Care Pharmacist (1999-2001)

- Responsible for starting and maintaining a pharmaceutical care practice at 3 Eckerd Stores.
- Appeared in National Eckerd/Celebrex commercial.

HMO Account Services Manager (1997 - 1999)

- Served as a liaison between all HMO organizations contracting with Eckerd in 26 states.
- Responsible for improving financial agreements.
- Responsible for helping to streamline processing of HMO prescriptions.

District Pharmacy Manager (1993-1997)

- Responsible for pharmacy operations in 30 Eckerd Drug Stores.
- 1994 Eckerd District Pharmacy Manager of the Year.

Pharmacy Manager 1984-1992

- Prepare prescriptions for patients, provide consultation to patients.
- Maintain financial goals, sales, inventory and payroll.
- Member of Eckerd's Public speaking bureau-interviewed by television, newspaper, and made several training videos.

Academic Background

University of Florida

- Doctor of Pharmacy
- Received Excellence in Pharmaceutical Care Research Award – Presented for the best thesis project

University of Pittsburgh

- B.S., Pharmacy
- Graduated Summa Cum Laude
- Recipient of Merck Award for scholastic achievement

References

Jason Stenta, Vice President of Health Plans, CVS Health

- Phone: 401-636-7309
- Address: One CVS Drive; Woonsocket, RI 02895

Steve Cohan, Senior Vice President of Health Plans, CVS Health

- Phone: 401-770-7460
- Address: Once CVS Drive; Woonsocket, RI 02895

Kim McDonnell, Vice President of Government Services

- Phone: 480-391-4600
- Address: 9501 East Shea Blvd.; Scottsdale, AZ 85260

JOJO YOUNG, CPA

Career History

WellCare Health Plans, Inc., Tampa, FL

Vice President, Health Plan Finance (July 2014 – Present)

- Directs and manages all aspects of Financial Forecasting, Planning and Analysis related to, but not limited to, operating budget, annual and multi-year and strategic planning, performance management and reporting, revised forecasting, monthly financial reporting to the executive leadership team, operational and administrative trend and variance analysis, sound budgeting and monitoring practices and financial analysis of performance for the individual Health Plans.
- Directs the Health Plans forecasting and planning. Actively participates in business planning, providing strategic input and recommendations to improve the overall plan performance.
- Contributes to the CFO and senior team's corporate-level strategy formulation and decision-making process.
- Builds strong, collaborative partnerships between finance and the field leadership teams to facilitate and drive key deliverables such as the financial forecasts, budgets and business cases.
- Assess the strengths and weaknesses of the company's financial management strategies and implement steps to improve them.
- Responsible for developing financial proforma's for all Greenfield and Brownfield expansion activities for all lines of business based on input from collaboration with all impacted operating groups and regional departments.
- Provides executive project management for implementation of key initiatives (e.g. MEIs) and drives critical projects from conception, through implementation and execution.
- Responsible for integration of Acquisitions from a Financial Planning and Analysis perspective. That includes building a financial proforma, current operating budget and financial analysis of performance.
- Builds, develops and directs staff capable of carrying out company initiatives. Direct reports include other executives, managers and/or exempt individual contributors.

Senior Director, Financial Planning & Analysis (June 2012 – July 2014)

- Responsible for all membership and SG&A budgeting, forecasting and financial analysis for all WellCare markets.
- WellCare markets total annual SG&A spend is $280M with membership totaling 2.5M.
- Manage the detailed preparation of the bottom up annual budget and monthly budget reforecasting.
- Perform routine and ad hoc complex financial analysis work including evaluating financial information and preparing reports indicating trends.

- Develop strategies and ensure maximum efficiencies in the utilization of human and financial resources.
- Provide recommendations to management and responding to market inquiries for professional counsel related to financial information.

Senior Director, Florida Division Finance (February 2008 – July 2012)

- Interim Finance Lead for Hawaii from 3/10 to 9/10.
- Assisted will revenue reconciliation, cost share receivable reductions, medical expense initiatives and all other finance functions.
- Lead Finance role for 3 Florida Regions with approximately $1.8 billion in revenue.
- Develop and track annual medical cost savings initiatives worth approximately $10 million a year.
- Lead strategic monthly Regional Market Meetings with Senior Management.

Director, Finance (May 2005 – February 2008)

- For Sarbanes Oxley compliance, I led a team in locating and auditing over 20,000 Provider contracts to ensure we were paying Providers based on the terms of the contract.
- Led a project team in implementing a lockbox program to collect premiums from our members in our new $600 million Medicare Prescription Drug Plan.
- Responsible for organizing, facilitating and reporting to Senior Management results from monthly P&L meetings with each Regional Leadership team.

Eckerd Corporation, Largo, FL

Senior Director, Financial Planning and Analysis (February 2001 – January 2005)

- Responsible for building annual $15 billion budget using both the Top Down and Bottom Up approach while partnering with Senior Executives.
- Supervised the allocation of the annual budget to 2,700 stores, 5 ancillary units and all corporate and region overhead.
- Worked with parent company (JCPenney) to consolidate the Enterprise annual budget.
- Supervised and prepared weekly Monday financial report for Senior Executive staff meeting. One hundred plus page package included weekly financials compared to plan and forecast, key weekly metric summaries, TY/LY departmental results, seasonal merchandise sales, and industry trends.

Senior Manager Strategic Planning and Analysis (May 2000 – February 2001)

- Assisted in building annual budget and responsible for allocating the budget to all entities and loading and tying out the budget into Hyperion.
- Conducted weekly meetings with the ten Regional Controllers to review region-related goals and objectives (comp sales, competition, new stores, closed stores, strategic plans, etc.).

Academic Background

St. Bonaventure University, New York

- Bachelor of Business Administration

References

Gus Keriazes, Director, Provider Contracts, Molina Healthcare

- Phone: 813-675-9125
- Address: 3450 Buschwood Park Drive, Suite 200; Tampa, FL 33618

Jigar Desai, CFO, Freedom and Optimum Health Care Plans

- Phone: 813-466-9095
- Address: 5403 N. Church Ave.; Tampa, FL 33614

James Beermann, Vice President, Strategy, BayCare Health System

- Phone: 813-230-8338
- Address: 2985 Drew St.; Clearwater, FL 33759

AMBER BARTO

Career History

WellCare Health Plans, Inc. Tampa, FL

Senior Director, Market Compliance – Compliance Liaison (January 2015 - Present)

- Assist the Chief Compliance Officer in carrying out the oversight responsibilities associated with the Corporate Integrity Agreement and WellCare's Compliance Program, including the Code of Conduct and Business Ethics.
- Manage all Market Compliance Directors/Compliance Liaisons.
- Ensure compliance with all applicable state and federal regulations, including WellCare's obligations under the Corporate Integrity Agreement.
- Identify, escalate and oversee remediation efforts to comply with federal, state, local laws and regulations and/or contractual requirements.
- Continually assess the efficiency and effectiveness of the Compliance Program and implement enhancements.
- Validate LIONS Correspondence entries for timely and accurate submission
- Collaborate with Market leadership and Corporate functions in developing solutions for complex compliance and business problems to reduce the risk of fines, penalties and/or litigation.
- Monitor contractual requirements, the submission of required regulatory reports, health care compliance issues, trends and benchmarks in order to advise the Chief Compliance Officer and Market Leadership of emerging or potential compliance risks.
- Create, assist and monitor Corrective Action Plans (CAP) and Internal Action Plans (IAP) to ensure issues are effectively resolved and completed timely.
- Collaborate with Internal Audit, Corporate Oversight, Regulatory Affairs, Government Affairs, Delegated Oversight, Special Investigation teams, and Legal departments to monitor compliance.
- Provide compliance guidance and oversight to the executive team and market.
- Market's subject matter expert for HIPAA, Privacy and record retention.
- Continually assess and monitor the effectiveness of Market Compliance via Monthly Compliance Liaison Reports.
- Report Market compliance results to the Chief Compliance Officer, Market President, and executive leadership via Quarterly Performance Report Work plans.
- Monitor and track compliance program training requirements.
- Provide specialized compliance training to all associates.
- Chair the Market Compliance Oversight Committee.

Kaiser Permanente, Rockville, MD and Honolulu, HI

Audit Senior in Internal Audit Services (December 2009 – December 2014)

- Effectively prepared and executed a well-developed audit plan and document high quality work papers for complex operational and regulatory compliance audits.
- Documented business systems and processes using narrative and flowchart techniques.
- Provided innovative & creative ideas to formulate new and improved audit approaches, tools and techniques for high risk areas.
- Analyzed, created, and reviewed findings, root causes, opinions, and recommendations
- Communicated detailed results and recommendations through audit reports and verbal presentations.
- Ensured compliance with policy & procedures, contracts, regulations, including Centers for Medicare & Medicaid Services (CMS).
- Successfully managed internal/external relationships, including CFO's and external auditors (KPMG).
- Internalized Sarbanes-Oxley (SOX) 404 and performed testing for multiple business areas.
- SOX leader for Revenue Cycle: train staff, create/manage schedules, oversee/review testing, provide performance evaluations, monitor budgets, and communicate results to key stakeholders.
- Managed 15 audit staff across 8 US regions.
- Established SOX testing strategies to implement efficiencies reducing hours by 1500 or 25%.
- Conduct investigations, resulting in employee termination and/or process improvement.
- Developed and implemented an incentive program for the Internal Audit function.
- Lead for the ACL Task Force, Policy & Procedure Committee, Senior Forum, and Mentor Program.
- Member of the Compliance Operations Committee and Fraud Prevention & Loss Recovery Committee.
- Participated in the Revenue Cycle Integrated Risk Management (IRM) work throughout all KP regions as part of the Revenue Cycle Risk Coordination Committee (RCRCC).

Deloitte & Touché LLP, Pittsburgh, PA

Audit In-Charge in Audit & Enterprise Risk Services (June 2006 – November 2009)

- Solid experience in SEC financial reporting, including Forms10-Q and 10-K.
- Client service industry experience in Manufacturing, Retail, Higher Education, Non-For-Profit, Contracting, Healthcare, and Employee Benefit Plans.
- Conducted comprehensive financial audits, operational audits, federal and state compliance audits, and agreed-upon procedures.
- Supervised 3-8 staff continuously to assure completion of audits.
- Scoped, facilitated and performed testing to ensure clients were in compliance with the Sarbanes-Oxley Act by identifying risks, documenting controls, developing action plans, and designing and executing test plans.
- Completed walkthroughs of design and implementation of internal controls.
- Tested operating effectiveness of entity-level controls.
- Evaluated inefficiencies and developed recommendations to relay to management and/or audit committees.
- Developed individual audit programs for audit engagement specific areas.

- Developed and executed a reorganization plan to improve quality and quantity of work performed while reducing staffing and budget by over 13%.
- Created international correspondence documents for a subsidiary located in England, which consists of Referral Instructions, UK vs. US GAAP Questionnaire and Analysis, Global Internal Control Instructions, and budget.
- Continuous communication with Executives, CEOs, Board of Directors, and Audit Committees.
- Steered the Diversity Committee, FOCUS - School to Work Committee, Junior Achievement, and firm sponsored community events.

AVI Food Service, Inc., Slippery Rock, PA

Manager (September 2003 – May 2006)

- Hired, trained, and supervised 30+ employees over 6 locations.
- Successfully developed and implemented new sales and marketing strategies to increase sales.
- Managed and improved customer service by responding to questions, resolving complaints, and striving to exceed expectations.
- Responsible for disciplinary procedures and corrective actions for students in violation of established policies and procedures, including termination.
- Coordinated events for the President's Office and University Offices.

Academic Background

Slippery Rock University of Pennsylvania, Slippery Rock, PA
- Bachelor of Science in Business Administration

References

Frank Fisher, Deloitte Tax Partner
- Phone: 412-338-7918
- Address: 2600 One PPG Place; Pittsburgh, PA 15222

Crystal Busey, Manager Medicaid Programs, Kaiser Permanente
- Phone: 808-778-0731
- Address: 711 Kapiolani Blvd.; Honolulu, HI 96813

Victoria Tang, Audit Project Manager, Kaiser Permanente
- Phone: 510-229-2001
- Address: 393 E. Walnut St.; Pasadena, CA 91188

CORPORATE OVERVIEW

J. SUB-CONTRACTORS

If the bidder intends to Sub-Contract any part of its performance hereunder, the bidder must provide:

vi. name, address, and telephone number of the Subcontractor(s);

vii. specific tasks for each Subcontractor(s);

viii. percentage of performance hours intended for each Subcontract; and

ix. total percentage of Subcontractor(s) performance hours.

Subcontractors: Our Experience Driving Their Performance

To complement our internal capabilities, WellCare contracts with best-in-class service providers to offer the most advanced and effective services for our members and providers. We see our business relationship with subcontractors as one element of our long-term business strategy. We carefully select and monitor subcontractors who can provide outstanding service to our members and our organization as a whole. Each market drives the decision regarding which subcontractors are selected and in what capacity they are to be used. The subcontractors selected to work on our Heritage Health Plan will reflect the skills needed to execute on the MLTC's respective goals for its Medicaid program.

Figure 5 is a list of key subcontractors we propose to use to serve Nebraska's Heritage Health members and providers. The table below details demographic information for each proposed subcontractor along with an estimation of the percent of our time the subcontractor will spend engaged in activities to support Heritage Health members.

Figure 5

SUMMARY LIST OF PROPOSED KEY SUBCONTRACTORS				
Proposed Subcontractor Name	**Address**	**Telephone Number**	**Services to be Provided**	**Percentage of Performance Hours**
Administep.com LLC	4965 Preston Park Blvd., Suite 600 Plano, TX 75093-5150	(214) 440-3127	Clearing House Services for Claims and Real-Time Transaction	0.04%
Advanced Medical Reviews	2950 31st Street Ste. 100 Santa Monica, CA 90405	(424) 235-1107	Utilization Management Review & Determination	0.74%
Alere Health Improvement Company	13625 Technology Drive Eden Prairie, MN 55344	(612) 632-2796	Maternity Risk Assessment & High-Risk Case Management	1.11%
American Well	75 State Street, 26th Boston, MA 12109	(617) 204-3699	Telemedicine Services	0.55%
Audiology Distribution LLC, d/b/a HearUSA	10455 Riverside Drive Palm Beach Gardens, FL 33410	(561) 478-8770	Hearing Management Services Vendor	0.74%
CareNet Healthcare Services (Infomedia)	11845 IH 10 West Ste. 400 San Antonio, T 78230	(210) 595-2084	24 Hour Nurse Line	0.74%
CDR Associates, LLC	307 International Circle, Suite 300 Hunt Valley, MD 21030	(615) 472-1353	Credit Balance – Recovery	0.37%

SUMMARY LIST OF PROPOSED KEY SUBCONTRACTORS				
Proposed Subcontractor Name	**Address**	**Telephone Number**	**Services to be Provided**	**Percentage of Performance Hours**
Comprehensive Health Management, Inc. **(WellCare's shared services organization)**	8735 Henderson Road Tampa, FL 33634	(813) 206-2702	Management Services	14.77%
Concentrix	Unit #101, 2nd Floor Westend Mall, District Centre Janakpuri, India	(510) 668-3603	Claims Processing Services	6.28%
Council for Affordable Quality Healthcare	1900 K. Street NW Washington, D.C., 20006	(202) 517-0400	Third Party Liablity	0.09%
CSI Southeast Inc., d/b/a Interpretek	75 Highpower Road Rochester, NY 14623	(407) 339-4835	Sign Language Interpretation	0.09%
CVS Caremark	One CVS Drive Woonsocket, Rhode Island, 02895	(847) 559-5445	Pharmacy Benefit Manager	2.95%
CyraCom International, d/b/a Voiance Language Services	5780 North Swan Rd. Tucson, AZ 85718	(520) 745-9447, ext 6032	Telephonic Translation Services	0.09%
Eliza Corporation	75 Sylvan Street, Suite B-205 Danvers, MA 01923	(978) 236-7362	Interactive Voice Recognition – Member Risk Assessments	0.18%
eviCore Healthcare LLC, f/k/a CareCore	400 Buckwalter Place Blvd Bluffton, SC 29910	(800) 918-8924, ext 27982	Utilization Management Services	1.48%
Financial Recovery Group	14707 S. Dixie Highway, Suite 401 Miami, FL 33176	(305) 232-7125	Claims Review and Overpayment	0.09%
First Recovery Group, LLC	26899 Northwestern Hwy., Ste. 250 Southfield, ME 48033	(248) 200-3888	Third Party Liability – Subrogation	0.74%
FOCUS Health, Inc.	10801 Starkey Rd. #104-101 Seminole, FL 33777	(727) 249-3929	Behavioral Health Utilization Management	0.37%
HealthIntgrated	10008 N Dale Mabry Hwy. Tampa, FL 33618	(813) 388-4043	24/7 Behavioral Crisis Line	0.18%
Health Management Systems, Inc.	360 Park Ave. South, 17th Floor New York, NY 10010	(215)910-1543	Third Party Liability – Coordination of Benefits, Credit Balance, Data Mining	0.28%
LifePlans, Inc.	51 Sawyer Rd, Suite 340 Waltham, MA 02453	(813) 361-5176	Call Center Services (Live Member Health Assessments)	0.55%

Summary List of Proposed Key Subcontractors				
Proposed Subcontractor Name	**Address**	**Telephone Number**	**Services to be Provided**	**Percentage of Performance Hours**
McKesson Health Solutions	5995 Windward Pkwy Alpharetta, GA 30005	(770) 237-1144	Clearing House	0.09%
Medical Transportation Management, Inc. (MTM)	16 Hawk Ridge Dr., Lake Saint Louis, MO 63367	(636) 695-5775	Transportation Services	0.18%
Multilingual Group, Inc.	18-44 College Point, NY 11356	(212) 686-1333	Written Translation Services	0.09%
ONEIL Digital Solution, LLC	3100 E. Plano Parkway Plano, TX 75024	(972) 608-4128	Print Services	0.37%
Premier Eye Care	4205 W Atlantic Ave., Suite 01 Delray Beach, FL 33445	(561) 455-9002 ext 222	Vision Management Services	1.85%
RR Donnelley & Sons Company	35 West Wacker Drive Chicago, IL 60601	(813) 218-5506	Print Services	1.11%
Symphony Performance Health, Inc., d/b/a SPH Analytics	11545 Wills Road Alpharetta, GA 30009	(678) 689-0314	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	0.74%
Syrtis Solutions, LTD	6380 Folsom Drive Beaumont, TX 77706	(703) 203-7279	Third Party Liability – Verification of Benefits Eligibility	0.28%
TPUSA, Inc. (Teleperformance)	6510 S. Millrock Dr. Ste. 150 Holladay, UT 84124	(801) 502-1819	Customer Service	11.93%
Translation Station, Inc.	3921 Flowers Road Atlanta, GA 30360	(770) 234-9387	Interpreter Services - Providers' Offices	0.07%
TransUnion Healthcare, Inc.	555 W. Adams St. Chicago, IL 60661	(704) 970-1435	Third Party Liability	0.04%
			Total Percentage of Subcontractor(s) Performance Hours	47.35%

TECHNICAL APPROACH

TECHNICAL APPROACH

A. Understanding of the project requirements (limited to three pages)

WELLCARE, HERITAGE HEALTH ARE A PERFECT FIT: UNDERSTANDING PROJECT REQUIREMENTS

WellCare of Nebraska, Inc., a subsidiary of WellCare Health Plans, Inc. has spent more than a year meeting with Nebraska Medicaid members, providers, advocates and stakeholders to fully assess the needs and opportunities of the state's Medicaid program. We have engaged staff members from every functional area of our enterprise and studied closely the requirements for the provision of full-risk, capitated Medicaid managed care for physical health, behavioral health, and pharmacy services provided to members of the Nebraska Heritage Health program. We fully understand and accept the requirements outlined in the Project Description and Scope of Work of this RFP, as well as each of the attachments, including the financial guidelines and rates. Additionally, we are well versed in federal regulations governing Medicaid managed care programs, as well as state laws, the Nebraska State Plan Amendment, waivers and other regulations governing the Heritage Health program.

Through our deep understanding of the project requirements, our understanding of the specific and unique needs of Nebraska Medicaid members and the system that serves them, as well as the goals of the Division of Medicaid and Long Term Services (MLTC), we believe there is no company better positioned to serve Nebraska's Heritage Health members than WellCare of Nebraska.

WellCare specializes exclusively in serving members of government-sponsored health care programs, including Medicaid, Children's Health Insurance Programs (CHIP), Medicare Advantage, Prescription Drug Plans and the Health Insurance Marketplace. As such, we are one of the largest providers of Medicaid managed care services in the country and have an infrastructure that today serves about 3.8 million people across all lines of business and provides solid experience for every aspect of this project. As Nebraska continues to take bold steps to modernize its Medicaid program, ***WellCare's focused approach aligns perfectly with MLTC's goals of improving health outcomes, enhancing integration, emphasizing person-centered care, reducing the rate of costly and avoidable care and improving the financial sustainability of the system.***

WellCare Health Plans' Experience with Medicaid Modernization Efforts

WellCare has helped transform Medicaid service delivery models in some of the country's largest and most complex states, including Kentucky, Georgia, Florida, and Hawaii. We currently support 53 separate Medicaid, LTSS, and related products in nine states. We proudly provide person-centered managed care services to 2.4 million Medicaid members across the full spectrum of eligibility groups including, but not limited to the aged, blind and disabled (ABD), home and community based services (HCBS) waiver, Foster Care, Children's Health Insurance Programs (CHIP), Temporary Assistance to Needy Families (TANF), supplemental security income (SSI), and long-term services and supports (LTSS) populations.

As an organization dedicated solely to improving the health and lives of members enrolled in government programs, WellCare's technical expertise in product development, administrative processing, network development, member and provider services, care management, quality, and information technology systems and infrastructure is focused on providing precisely the types of services sought for Nebraska.

Applying WellCare's unique brand of Medicaid managed care to Nebraska

Based on our experience with Medicaid and, more importantly, Medicaid modernization efforts, we understand the importance of having intimate knowledge of prospective members' needs along with a deep understanding and appreciation for the unique attributes and challenges inherent to each individual state in which we operate. Since 2014, we have made it a priority to understand the Heritage Health populations. Our team of business development and outreach staff has canvassed the state for months,

meeting with local community stakeholders across the state including Scottsbluff, the tri-cities area, Omaha, Lincoln and the Northeast region of the state. A sampling of these engagements included:

- Provider organizations including the Nebraska Hospital Association, the Nebraska Medical Association, Leading Age of Nebraska, Nebraska Health Care Association, Nebraska Association of Behavioral Health Organizations, Nebraska Pharmacists Association, Health Center Association of Nebraska, National Association of Social Workers (Nebraska Chapter)
- Tribal clinics including those with the Santee Sioux, Winnebago, Omaha and Ponca Nations
- Individual providers including Boys Town, Children's Hospital and Medical Center, University of Nebraska, SERPA ACO, Nemaha County Hospital and Centerpointe, among others.
- FQHCs including People's Health, Charles Drew, Heartland Health Center and OneWorld
- Social Service Agencies and Advocates like Community Action Agencies, AARP, the ARC of Nebraska, Sienna Francis House, Salvation Army, Clyde Malone Community Center, Child Advocacy Center, Salvation Army, Together, Inc. various food banks and several more.
- Government programs including various individuals with regional public health agencies and regional behavioral health authorities

Additionally, we held multiple focus groups with Medicaid members including ABD members and moms of children in the TANF/CHIP programs from both urban and rural communities.

These interactions provided invaluable insight that shaped our understanding of the requirements for this project to be successful and informed our strategy for Nebraska. A sampling of what we heard includes:

- There is a strong appetite for integration and collaboration between behavioral and physical health
- Providers seek additional support from Medicaid managed care to be innovative, co-locate, enhance their participation in value-based purchasing programs, engage in telehealth and adoption of electronic health records
- The system is ripe for increased data exchange and the use of data and evidence-based decision support tools to drive performance improvement and better health outcomes
- Rural and frontier communities continue to face challenges with access to services
- Foster Care children need focused support to address their continuum of care
- There is opportunity to expand access to evidence-based and recovery-focused services, particularly for children with Serious Emotional Disturbance
- Members need support in navigating through unique social determinants of health such as housing instability, transportation and food insecurity
- Members want simple, culturally competent information that eases their efforts navigating an often complex and sometimes difficult to access health care system

WellCare of Nebraska has developed our comprehensive Heritage Health strategy aimed at addressing the requirements of the project along with what we learned from our stakeholder engagement. Some key elements of that strategy, which is detailed in the accompanying pages of this proposal, are:

- Locally-based and locally-governed
  - We will locate Welcome Rooms with local staff in Scottsbluff, Omaha, Kearney and Norfolk in addition to our main office in Lincoln.
  - Key staff operating within Nebraska and supported by additional required staff in-state will have accountability to design program and make decisions that are best for Nebraskans.
- Person-Centered
  - We will offer field-based in-home care management for members with the highest acuity levels including a specialized program for Foster Care Children.

- Our Care Model incorporates person-centered care planning, including social supports and social interactions planning, and Interdisciplinary Care Teams.

- Fully Integrated
  - WellCare offers a fully integrated program with behavioral and physical health under a single organizational structure. Our hybrid model for pharmacy also maximizes integration while leveraging best-in-class core operations infrastructure.
  - Our Medical Management Platform and Information Technology Solutions offer a comprehensive view of each member highlighting their entire care record and engagement history in one place.
- Responsive to members' psychosocial needs
  - WellCare's proprietary Health*Connections* model will offer Nebraska an industry-leading approach to connecting members to social safety net resources with our CommUnity Assistance Line, Navigator Database, Local Community Outreach specialists and HealthConnections Councils that work in local communities to identify needs.
- Quality focused
  - WellCare's network development plan is grounded in the ideas of offering members the highest quality care. We offer a Value-Based Purchasing program focused on improving quality.
  - We offer an array of data and decision support tools to measure individual and system performance and engage in a continuous cycle of improvement.
- Collaborative and Transparent
  - We believe in building collaborative relationships with our contracted providers, empowering them with actionable member specific and population health data, as well as a number of supports to help enhance operational effectiveness, and ultimately, improved health outcomes.
  - We include several opportunities for members, providers and stakeholders to engage with us including an array of formal and informal touch points, designated points of contact, committees and councils to ensure there is effective two-way communication.

DEPLOYING WELLCARE VALUES IN NEBRASKA: A NOTE ON UNDERSTANDING THIS PROJECT

Our company is driven by four values: Accountability, Integrity, Partnership and Teamwork. These values underpin everything we do as an organization and are supported at the highest levels of our executive and operational structure, including in developing this response.

- **Integrity:** We do what we say we're going to do. WellCare has adopted and industry leading process to certify to the contents of the documents submitted in connection with this proposal. This process spans several days and involves multiple layers of attestation with associates at the front-line, management and executive leadership levels signing off on the content and strategies proposed.
- **Accountability:** WellCare values the public trust and understands that when operating in the public space, transparency is a premium. To that end, we have elected to not redact any material within this proposal. We believe it's critical that stakeholders in the system have a complete view of what we have offered here and what we expect to be held accountable to should we be awarded a contract.
- **Partnership:** We didn't just create this proposal in a silo. We partnered with individuals in Nebraska – hiring local consultants and meeting with stakeholders from across the state over the past year to shape something that we could confidently believe matches the unique needs of Nebraska.
- **Teamwork:** Nearly 100 people across WellCare touched this proposal. We worked together to build strategies across functional areas that meet the needs of Nebraskans.

TECHNICAL APPROACH

1. If applicable, describe the MCO's proposed risk bearing partnerships/relationships including designated functions of each entity, and how delegated functions will be overseen. *(Page limit 2 pages)*

WELLCARE'S PROPOSED RISK BEARING PARTNERSHIPS

Currently, WellCare of Nebraska is not proposing any risk bearing partnerships or relationships as part of our strategy to manage care for Heritage Health members.

TECHNICAL APPROACH

2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.

REGULATORY ACTIONS, SANCTIONS, LETTERS OF DEFICIENCY AND CORRECTIVE ACTION PLANS

Overview

WellCare takes any regulatory action or sanction received seriously. Our Compliance team works with our local plan personnel and other operational groups as necessary to investigate the underlying circumstances and where a deficiency has occurred we perform a root cause analysis to help prevent recurrences. We have put in place numerous processes designed to ensure we comply not only with applicable laws and regulations but with our contractual commitments as well. These include:

- **Automated Tracking Systems**. We use a multi-faceted system that helps us both track our compliance with contractual requirements and administer our policies and procedures and internal action plans. With respect to contractual requirements, our automated system generates assessment requests and sends them to the applicable process owners to assess compliance with the requirements. The system then identifies gaps and tracks internal remediation plans. With respect to policies and procedures, the system provides a central searchable repository for all policies and procedures and tracks the date when each was last revised to ensure they are reviewed not less than annually. We also use another automated system to track reports submitted to regulatory agencies and other correspondence with regulatory agencies. This helps ensure all reports are submitted on a timely basis.
- **Audits and Monitoring**. WellCare has established an Internal Audit function whose mission is, in part, to help ensure WellCare and its associates comply with state, federal and regulatory requirements including applicable policies, standards, procedures, laws and regulations. Each year Internal Audit develops and executes a formal audit plan. The audits conducted by Internal Audit help to identify potential areas of non-compliance and opportunities for improvements in processes.
- **Compliance Hotline**. WellCare offers its officers, directors and associates multiple ways to report a compliance concern, including both a phone and web-based hotline. Reports made to the hotline may be made anonymously. The hotline is maintained by a third party, EthicsPoint, to help assure associates of their anonymity if they wish it. WellCare's policy of non-retaliation, included in its Code of Conduct and communicated through multiple channels, also helps to ensure associates and others are comfortable reporting any compliance concerns they may have.
- **Discipline.** WellCare maintains a disciplinary policy for compliance violations. Associates who violate laws, regulations or WellCare policies are subject to discliplinary acton, up to and including termination of employment. Likewise, such violations by subcontractors may result in the termination of their contracts with WellCare.
- **Policies and Procedures**. WellCare has adopted a comprehensive set of policies and procedures designed to, among other things, help ensure our operations comply with all applicable laws and regulations. WellCare recognizes that state laws and requirements can vary and we develop our policies and procedures accordingly. For example, we have adopted a number of grievance policies and procedures in order to ensure not only compliance with the requirements of Subpart F of 42 C.F.R. Part 438, but also compliance with applicable state laws. Recognizing there are different requirements applicable to each state, we have separate policies and/or procedures relating to

grievances for each of our Medicaid plans. As required by the accreditation requirements of the National Committee for Quality Assurance (NCQA), our policies and procedures are reviewed not less than annually to ensure they are kept up to date and reflect any changes in laws, regulations or contractual requirements.

- **Report Integrity**. WellCare has specific policies and procedures that ensure that all reports are appropriately reviewed, validated, certified and approved prior to their submission to any regulatory agency. The purpose of these policies and procedures is to help ensure that all submissions are accurate, complete, timely submitted, compliant and in accordance with all governing contractual provisions and the underlying laws and other requirements.

Further details about our comprehensive Compliance Program are included in our response to Question 10.

Regulatory Actions and Sanctions

None of WellCare or its subsidiaries has been excluded or debarred from participating in any federal or state procurement or non-procurement program. However, certain of WellCare's affiliates have received other types of sanctions and regulatory actions over the last five years related to our Medicaid and CHIP contracts. We ran the relevant reports to prepare our response on November 10, 2015, so the five year period covers November 10, 2010 – November 10, 2015. For convenience we have summarized these in Figure 1 below.

In Figure 1 "**AHCA**" is the Florida Agency for Health Care Administration, "**CHFS**" is the Kentucky Cabinet for Health and Family Services, "**DHFS**" is the Illinois Department of Healthcare and Family Services, "**DMAHS**" is the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, "**DSS**" is the Missouri Department of Social Services and "**ODJFS**" is the Ohio Department of Job and Family Services.

In addition to the regulatory actions summarized in **Figure 1**, please note that WellCare is currently operating under a Corporate Integrity Agreement. Details about our Corproate Integrity Agreement are included in our response to Question 3 of this RFP.

Figure 1

State	Issuing Agency	Subject	Type of Action or Sanction	CAP	Description
FL	AHCA	Claims	Liquidated Damages/ Fines	No	Claims processing timeliness did not meet 90 day processing performance standard. Aggregate liquidated damages of $10,000.*
FL	AHCA	Claims	Liquidated Damages/ Fines	No	Claims processing timeliness standards for assistive care services not met (one provider). Liquidated damages of $40,000.
FL	AHCA	Encounters	Liquidated Damages/ Fines	No	Pharmacy encounters not submitted timely. Aggregate liquidated damages of $50,000.
FL	AHCA	Financial	Liquidated Damages/ Fines	Yes	Failure to maintain financial surplus requirements as a result of placing the annual ACA premium payments within the first quarter. Liquidated damages of $43,000.
FL	AHCA	Network	Liquidated Damages/ Fines	No	Network deficiencies regarding birthing centers located within the service area. Liquidated damages of $3,000.

State	Issuing Agency	Subject	Type of Action or Sanction	CAP	Description
FL	AHCA	Network	Liquidated Damages/ Fines	No	Failure to timely remove three terminated facilities from the paper and online provider directory resulting in inaccurate information in provider directory. Aggregate liquidated damages of $8,500.
FL	AHCA	Network	Liquidated Damages/ Fines	No	Submission of Provider Network File one day past due date. Liquidated damages of $250.
FL	AHCA	Network	Liquidated Damages/ Fines	No	Provider Network File did not meet specifications. Aggregate liquidated damages of $25,500.
FL	AHCA	Reporting	Liquidated Damages/ Fines	No	Late submission of corrective action plan for child health check-up. Liquidated damages of $3,000.
FL	AHCA	Reporting	Liquidated Damages/ Fines	No	Submission of unaudited financials one day after deadline. Liquidated damages of $1,000.
FL	AHCA	Reporting	Liquidated Damages/ Fines	No	Claims Aging Report not submitted timely. Liquidated damages of $3,500.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Failure to meet internal corrective action plan standards tied to child health checkup. Aggregate liquidated damages of $73,000.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Failure to meet HEDIS performance standards in all respects. Aggregate liquidated damages of $131,500.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Child health check-up participation rate not met. Aggregate liquidated damages of $75,000.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Clinical performance measures for therapy services not met. Liquidated damages of $7,500.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Failure to mail a written notice of action within required timeframe. Liquidated damages of $2,500.
FL	AHCA	Utilization	Liquidated Damages/ Fines	No	Denial of speech therapy services for members under the age of 21. Liquidated damages of $17,500.

State	Issuing Agency	Subject	Type of Action or Sanction	CAP	Description
IL	DHFS	Quality	Auto-Enrollment Suspension	Yes	Suspension of auto-enrollment from November 11, 2014 – January 8, 2015 due to failure to meet certain threshold quality scores for the 2013 calendar year. Noting a lack of improvement from prior reported scores, DHFS concluded that the plan had not adopted adequate practice guidelines to meet certain contractual requirements. Suspension lifted after DHFS determined that the plan had made substantial progress.
IL	DHFS	Network	Auto-Enrollment Suspension	Yes	Suspension of auto-enrollment from November 5, 2015 – present in Illinois' Region 5 due to failure to correct certain network deficiencies in that region. The plan has been required to obtain participating provider contracts rather than single case agreements for services. The plan is currently negotiating these participating provider cotnracts.
KY	CHFS	Administrative	Liquidated Damages/ Fines	No	Late submission of a response to a letter of concern. Liquidated damages of $6,500.
KY	CHFS	Encounters	Liquidated Damages/ Fines	No	Liquidated damages related to encounter data reporting. Aggregate liquidated damages of $727,235.
KY	CHFS	Encounters	Payment Withholds	No	Submission of encounter files that either failed the SNIP edits or had another front end failure. CHFS withheld $10,134,654.14 and $10,847,823.64, in November 2014 and April 2015, respectively. In each case, the full amounts withheld were released to WellCare of Kentucky the following month after successful resubmission of the files.
MO	DSS	Quality	Intermediate Monetary Sanction	No	Failure to provide behavioral health services to members. No corrective action plan was required because between the time the deficiencies had been identified and the sanction was imposed, the plan had contracted with a new subcontractor for behavioral health services. Intermediate sanction of 0.47 percent of the plan's monthly capitation payment for the May 5, 2011 payment cycle.

State	Issuing Agency	Subject	Type of Action or Sanction	CAP	Description
NJ	DMAHS	Encounters	Payment Withholds	No	Payment withholds related to a "rolling" withhold system in which deficiencies are calculated monthly based on the encounter records submitted through the previous month. Amounts may be released once the deficient encounter records have been corrected and resubmitted. Amounts withheld become liquidated damages after 12 months if the encounters have not been corrected and resubmitted. To date, the plan has been assessed approximately $93,000 in liquidated damages under this system. For service months through January 2015, $1,180.993 remained on withhold through November 4, 2015.
OH	ODJFS	Quality	Liquidated Damages/ Fines	No	State performance standard not met for high risk care management. Liquidated damages of $300,000.

** Liquidated damage estimates include items that are under reconsideration or appeal with the applicable regulatory agency. As such a portion of the penalties assessed may be returned to WellCare pending the outcome of the reconsideration or appeal.*

Letters of Deficiency and Corrective Action Plans

WellCare and its subsidiaries from time-to-time receive letters of deficiency and corrective actions. **Figure 2** below summarizes the letters of deficiency and corrective action plans imposed on WellCare and its subsidiaries related to our Medicaid and CHIP contracts within the last five years (November 10, 2010 – November 10, 2015). Please note that because letters of concern are usually informational and do not rise to the level of a CAP, we did not believe them to be responsive to this question and have not included them. Information regarding letters of concern is available upon request.

In **Figure 2** "**AHCA**" is the Florida Agency for Health Care Administration, "**CHFS**" is the Kentucky Cabinet for Health and Family Services, "**DCH**" is the Georgia Department of Community Health, "**DHFS**" is the Illinois Department of Healthcare and Family Services, "**DHHS**" is the South Carolina Department of Health and Human Services, "**DHS**" is the Hawaii Department of Human Services, "**DMAHS**" is the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, "**DOH**" is the New York State Department of Health, "**DSS**" is the Missouri Department of Social Services and "**ODJFS**" is the Ohio Department of Job and Family Services.

Figure 2

State	Issuing Agency	Subject	Type of Action	Description
FL	AHCA	Administrative	CAP	Newly hired associates not being trained timely on a on risk management program
FL	AHCA	Claims	CAP	Plan not providing sufficient claims submission support to specific providers
FL	AHCA	Network	CAP	DME provider template failed to meet contractual requirements

State	Issuing Agency	Subject	Type of Action	Description
FL	AHCA	Network	CAP	Inaccuracies between the updated network list submitted to the agency and printed provider directory
FL	AHCA	Reporting	CAP	Behavioral health claims not included on Claims Aging Report
FL	AHCA	Utilization	CAP	Behavioral health claims being denied for services provided to members eligible for Home Safe Net but who had not yet been enrolled in a Child Welfare Prepaid Mental Health Plan
FL	AHCA	Utilization	CAP	In connection with decisions to deny or authorize therapy services, a subcontractor was using criteria that were not compliant with contractual requirement
GA	DCH	Network	CAPs	CAPs related to deficiencies identified in quarterly network monitoring reviews - provider network accessibility and related CAPs to address data in provider listings
GA	DCH	Quality	CAP	Our Georgia plan is audited annually by the state's External Quality Review Organization (EQRO). CAPs requested from the 2011, 2012, 2013 and 2014 EQRO audits have covered various issues, including provider wait time standards, returning patient calls by providers, geographic access standards, provision of cultural competency plan on the website, form of QAPI program assessment, CPG (Clinical Practice Guideline) compliance by providers, performance goals, care management processes, disease management processes, transitions of care and discharge planning, monitoring case managers and assessment, care plan and discharge planning processes, coordination and continuity of care, revisions to member handbook and notice of action and EOB denial templates, improvements to UMAC minute
GA	DCH	Quality	CAPs	Failure to meet various performance targets for timely appointment acces
GA	DCH	Reimbursement	CAP	Erroneous NICU kick payment requests filed with incorrect diagnosis-related groups resulting in the return of an $82,842.77 overpayment
GA	DCH	Reporting	CAP	Failure to reconcile pharmacy rebates within agency deadline
GA	DCH	Reporting	CAP	Errors in PCP Assignment Report
GA	DCH	Utilization	CAP	Lack of authorization for a member's request for incontinence supplies covered under EPSDT benefit
HI	DHS	Administrative	CAP	Deficiencies in notice of action, grievances and appeals templates
HI	DHS	Network	CAP	Deficiencies related to obtaining disclosure statements from providers and provider contract template
HI	DHS	Quality	CAP	CAPs relating to EQRO visit – member and provider grievances and administrative issues

State	Issuing Agency	Subject	Type of Action	Description
HI	DHS	Quality	CAP	CAPs relating to EQRO audit – revisions to grievance, appeal and service authorization policies, timely processing of authorizations, revisions to member handbook, prior authorization reporting
HI	DHS	Various	CAP	CAPs relating to readiness review – various findings requiring CAPs from font size for large print materials to revisions to service plan development and exclusion check processes
IL	DHFS	Claims	CAP	DHFS requested CAPs from all participating plans relating to avoiding preventable errors in encounter data
KY	CHFS	Administrative	CAP	Brochure sent to an individual who was a recent former member of the plan
KY	CHFS	Administrative	Letter of Deficiency	Failure to provide access to plan's MIS system
KY	CHFS	Administrative	CAP	Plan must be able to provide identity and cover documents for undercover law enforcement officers
KY	CHFS	Administrative	CAP	Notice of action did not contain correct information regarding how to appeal an adverse decision
KY	CHFS	Administrative	CAP	Failure to meet call abandonment rate standards
KY	CHFS	Claims	CAP	Failure to comply with performance standards relating to processing clean claims
KY	CHFS	Encounters	CAP	Failure to achieve less than a five percent error rate for encounter data
KY	CHFS	Network	CAP	Deficiencies in provider network and reporting of same
KY	CHFS	Network	CAP	Issues related to actions taken by the plan's PBM which resulted in the appearance that certain active pharmacies were terminated in the system resulting in the delay in payment of claims but no delay on access to care
KY	CHFS	Quality	CAP	CAPs related to EQRO audit –behavioral health services, health risk assessments, care management and care coordination
KY	CHFS	Reporting	CAP	Deficiencies related to outstanding CAP (correspondence not provided in accordance with the CAP)
KY	CHFS	Reporting	CAP	Inaccuracies in provider network files resulted in the exclusion of hospitals from the state submission
KY	CHFS	Utilization	CAP	Historical data regarding prior authorizations not being transferred from plan to subcontractor
MO	DSS	Administrative	CAP	CAPs regarding various administrative matters – deficiencies in documentation regarding which positions held by in-state personnel, retention of report return receipts, FWA reporting documentation
MO	DSS	Encounters	CAP	Failure to submit attestations with encounter data

State	Issuing Agency	Subject	Type of Action	Description
MO	DSS	Network	CAP	Failure to comply with provider directory requirements
MO	DSS	Reporting	CAP	Deficiencies in the format and quality of data reported
MO	DSS	Quality	CAP	CAPs from BH clinical performance review including provider network analysis, BH training, care plan documentation, monitoring of care managers, reporting, improvements to discharge planning and involvement of BH medical director in complex cases
MO	DSS	Utilization	CAP	Erroneous imposition of prior authorization requirements for childhood immunizations
NJ	DMAHS	Administrative	CAP	Submission of incorrect address for community event
NJ	DMAHS	Quality	CAPs	Deficiencies related to care management in the case of two members - failure to contact a transitioned member to assess needs and enroll her in care management and failure to provide care management, medically necessary services and reimbursement for another member
NJ	DMAHS	Quality	CAP	CAPs from review of annual reports, including quality assurance activities, intervention efforts appointment availability and customer service
NJ	DMAHS	Reporting	Letter of Deficiency	Failure to submit quality committee agendas, sign in sheets and minutes
NJ	DMAHS	Reporting	CAPs	Deficiencies in grievance and appeals reporting
NY	DOH	Network	CAPs	CAPs related to audits of provider network regarding accuracy of information in provider directory
NY	DOH	Network	CAPs	Deficiencies in provider network
OH	ODJFS	Administrative	CAPs	Failure to comply with appeals and grievances timeframe
OH	ODJFS	Administrative	CAPs	Failure to meet call center abandonment rate and/or average speed of answer standards
OH	ODJFS	Encounters	CAPs	Failure to meet encounter data volume standards
OH	ODJFS	Quality	CAPs	Failure to meet access and/or clinical performance standards
OH	ODJFS	Utilization	CAP	CAPs related to EQRO review of pharmacy claims - drugs improperly denied as not covered, as prior authorization required and for members in transition
OH	ODJFS	Utilization	CAP	Failure to cover drugs covered by Ohio Medicaid under the EPSDT and general program
OH	ODJFS	Utilization	CAP	Failure to comply with the expense ratio standard
SC	DHHS	Administrative	CAP	Deficiencies related to credentialing and re-credentialing
SC	DHHS	Various	CAP	CAP related to a number of topics including data integration, governance, recording of health plan receivables, claims data and other matters

Iowa Medicaid Contract

On February 16, 2015, the Iowa Department of Human Services ("DHS") issued Iowa Department of Human Services - Request for Proposal - Iowa High Quality Healthcare Initiative - RFP MED-16-009 (the "Iowa RFP"). On August 17, 2015, DHS issued a Notice of Intent to Award contracts arising out of the RFP to four entities including WellCare of Iowa, Inc. ("WCIA"). Three unsuccessful bidders filed bid protests challenging the intended contract awards. Those protests were denied and each of the protestors timely appealed the denial of their protests to the Iowa Department of Inspection and Appeals, Division of Administrative Hearings in the case styled *Iowa Total Care, Inc. et al. v. Iowa Department of Human Services, et al.*, Appeal Nos. 16001573, 16001590, and 16001623. During the pendency of those appeals, the winning bidders, including WCIA, entered into contracts with DHS on October 9, 2015. On November 25, 2015, following an administrative hearing, Administrative Law Judge Christie J. Scase issued a Proposed Decision which, among other things, reversed the Notice of Intent to Award a contract to WCIA. WCIA, DHS, and the protesting bidders each sought review of the Administrative Law Judge's Proposed Decision. Review was granted and on December 18, 2015, Iowa Department of Administrative Services Director Janet E. Phipps (the "Director") issued a Final Order reversing the Notice of Intent to Award to WCIA and terminating WCIA's contract with DHS. WCIA disputes the facts and law as set forth in both the Proposed Order and Final Order and will seek judicial review of the Final Order, including the Director's decision to terminate the contract between WCIA and DHS. DHS' contact person, address and phone number for purposes of the now terminated contract is:

Mikki Stier, Medicaid Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
515-256-4647

TECHNICAL APPROACH

3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.

CRIMINAL OR CIVIL INVESTIGATIONS BY A STATE OR FEDERAL AGENCY

For purposes of this response, the "Company" refers collectively to WellCare Health Plans, Inc., the parent organization of WellCare of Nebraska, Inc., together with its subsidiaries and affiliates.

Investigations

2006 Qui Tams and Related Matters

In or about 2006, after certain then-current and former employees filed qui tam or "whistleblower" lawsuits alleging misconduct and seeking the recovery of monetary damages, federal and state enforcement authorities initiated investigations of the Company. These investigations have been successfully resolved, as summarized below. Moreover, all of the individuals whose actions or judgment were implicated by the factual allegations and legal claims asserted were separated or terminated from the Company by the end of 2008. ***During these investigations, the Company cooperated fully with these regulatory bodies and took extensive actions to remediate itself. A summary of some of these remediation efforts, which have transformed the culture of the Company, follows our discussion of the investigations.***

United States Attorney's Office / Florida Attorney General's Office

In May 2009 the Company agreed to enter a Deferred Prosecution Agreement (DPA) with the United States Attorney's Office (USAO) for the Middle District of Florida and the Florida Attorney General's Office. The DPA resolved the investigations regarding the matters above by those offices without adjudication of the matter on its merits.

As part of the DPA, the Company retained an independent monitor (the "Monitor") from August 2009 to February 2011. Among other things, the Monitor reviewed and evaluated the Company's compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Company successfully completed the Monitorship in February 2011.

On April 3, 2012, the USAO and the Florida Attorney General's Office notified the Company that they agreed to an early termination of the DPA. On April 4, 2012, the Federal Court granted the USAO's motion to dismiss the charges contained in the Information with prejudice.

Civil Division of the United States Department of Justice

In connection with the government investigation, the Company learned that four federal *qui tam* complaints (the "Federal *qui tam* complaints") had been filed by relators against the Company under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733 and one *qui tam* action had been filed against the Company in a Florida state court (the "Leon County *qui tam* suit"). The United States government elected to intervene in the Federal *qui tam* complaints.

These complaints arose from conduct which occurred in or before 2007. On April 26, 2011, the Company entered into settlement agreements (collectively, the "Settlement Agreements") with various government entities. Signatories for the various government entities were (a) the United States (the "Federal Settlement Agreement"), the United States Department of Justice, the Office of Inspector General of the Department of Health and Human Services (OIG-HHS) and the Civil Divisions of the United States

Attorneys' Offices for the Middle District of Florida and the District of Connecticut and (b) the following states: Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio. The Settlement Agreements became effective as of March 23, 2012. Under the Settlement Agreements the Company agreed, among other things, to pay the Civil Division of the United States Department of Justice (the "Civil Division") $137.5 million in installments over a period of up to 36 months after the effective date of the Federal Settlement Agreement plus interest.

As a result of the Settlement Agreements, the Federal *qui tam* complaints and the Leon County *qui tam* complaints were dismissed.

All amounts payable by the Company pursuant to the Settlement Agreements have been paid.

Corporate Integrity Agreement

As part of the settlement of the civil inquiries by the government, in April 2011, the Company also entered into a Corporate Integrity Agreement with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the matters relating to the Company under review by OIG-HHS. The Corporate Integrity Agreement requires that the Company maintain its existing ethics and compliance programs. These programs are designed to help ensure the Company's ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new associates, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company's reporting practices and bid submissions to federal health care programs.

2013 New York Investigation

WellCare received notice on June 10, 2013 that the United States Attorney's Office for the Northern District of New York was investigating allegations that WellCare of New York, Inc. knowingly accepted monthly Medicaid capitation payments from the State of New York and ultimately from the United States to which it was not entitled.

The USAO indicated that it was reviewing the payments made to 10 managed care organizations (MCOs) in New York for payments made to beneficiaries who at some point during their enrollment moved out of state. WellCare cooperated fully with the USAO investigation including internally researching the 20 beneficiaries identified as members of WellCare of New York. The USAO and the New York State Department of Health and Office of the Medicaid Inspector General entered into settlement agreements with the MCOs. The settlement agreements specifically stated that the government found no evidence of a False Claims Act violation or other wrongdoing by WellCare of New York. The settlement was based upon payment-by-mistake theory attributable to processing errors and omissions made by the New York Human Resource Administration rather than misconduct by the MCOs. The total settlement received from the MCOs was $1.3 million. WellCare of New York's share was $52,000.

Remediation

The Company has taken steps to significantly transform itself by remediating the issues that led to the government investigations described above and to build itself into a strong, well-governed, and compliant company. This change extends to WellCare's Board of Directors, which established two new committees in 2008. One of these committees, the Regulatory Compliance Committee, is focused on the compliance activities of the Company. The second of these committees, the Health Care Quality and Access Committee, is focused on the care of our plans' members. Highlights of these changes include:

- Change in the senior management team, including the removal of the Company's then CEO, CFO and General Counsel in 2008.
- Expansion of and improvements to its corporate ethics and compliance program including enhancements to the associate corporate ethics and compliance training program and implementation

of a Code of Conduct and Business Ethics and related policies and procedures. The corporate compliance program covers all aspects of our company and is designed to assist us with conducting our business in accordance with applicable federal and state laws and high standards of business ethics. The corporate compliance program applies to members of WellCare's Board, our officers and all of our associates. The following are several features of our compliance program:

- **Regulatory Compliance Committee.** The Regulatory Compliance Committee of WellCare's Board oversees our compliance activities and programs. This committee meets not less than quarterly. It receives periodic reports from our Chief Compliance Officer and is responsible, along with the Audit and Finance Committee of WellCare's Board, with assisting the Board with the oversight of WellCare's compliance activities.
- **Chief Compliance Officer.** Our Chief Compliance Officer reports directly to our Chief Executive Officer and the Regulatory Compliance Committee and is responsible for the day-to-day activities of the compliance program, including monitoring the timeliness and appropriateness of regulatory reporting and affiliated company arrangements, among other things.
- **Corporate Compliance Committee.** Our corporate Compliance Committee operates under a charter approved by the Regulatory Compliance Committee, is chaired by our Chief Compliance Officer and is comprised of members of senior management, including (among others) our Chief Legal and Administrative Officer, Senior Vice President, Operations, our Chief Auditor, Chief Information Officer and Chief Medical Officer. The corporate Compliance Committee assists WellCare's Board with overseeing the compliance program and reviews areas of legal, regulatory and compliance risk throughout the Company.
- **Communications with regulators.** We have implemented a comprehensive program to help us identify regulatory reporting issues and report such issues to the appropriate federal or state regulator. The program, which is administered under the supervision of our Chief Compliance Officer, is designed to ensure the timeliness, details and sufficiency of the information we communicate to regulators.
- **Compliance training.** Our corporate training program includes mandatory compliance training for all associates. New associates receive compliance training within 30 days of hire, while existing associates complete required compliance training on an annual basis. Associates who fail to timely complete such training are subject to disciplinary action.
- **Non-retaliation policies and multiple reporting channels.** As an integral part of the compliance program, we emphasize non-retaliation and provide a variety of channels for associates to express concerns, including an external hotline and web portal where information can be left anonymously.
- **Written policies and procedures.** We have adopted written policies and procedures to reflect our commitment to corporate integrity and compliance and our duty to report.

- Implementation of a Company-wide compliance management system to assist the Company in the management of its compliance responsibilities, retain attestations related to state contract compliance and to serve as a central repository for all corporate policies and procedures; and
- Implementation of a contractual reporting certification policy so that associates with the appropriate level of authority certify that reports provided to regulatory entities are complete and accurate.

SECTION III.F INSURANCE REQUIREMENTS

4. Describe the risk analysis, assumptions, cost estimates and rationale supporting the MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship. *(Page limit 2 pages)*

WELLCARE'S REINSURANCE APPROACH AND OVERVIEW

WellCare entities reinsure high dollar claim risk through the use of an external reinsurance vendor to mitigate claim fluctuation risk and stress on operating capital. WellCare has no immediate plans to utilize reinsurance through related parties at this time. Any future reinsurance coverage involving related parties would be submitted for approval through the normal contract approval process with the State.

The coverage terms are developed as part of the overall corporate risk management strategy described below. The contract will typically address the following terms:

- Policy Year contract period including eligible service dates, payment timeframe, and carryover provisions for claims that may be incurred during one contract period, but eligible to be counted for recovery in subsequent contract periods.
- Financial terms of coverage including deductible, coinsurance, and annual/lifetime benefits limits.
- Reimbursement schedule applicable for recoveries, which may be different than the reimbursement basis paid to the provider, may be tied to the minimum of the actual paid claims and a standard schedule such as 100% of Medicare or Medicaid.
- Services eligible for recovery reimbursement under the contract, or specific excluded services.
- General and supplemental insolvency coverage, if required for a given market.
- Data reporting and disclosure requirements, including process to file for recoveries.
- Key networks or providers which may be preferred or required for certain services such as transplants.
- Member census information and rate schedule by product/plan.
- Specific membership coverage that may differ from the standard coverage. (For example if a member is known to have a maintenance condition that requires $2,500,000, the reinsurer may propose coverage for that member at a higher deductible such as $3,000,000. This allows WellCare to reinsure the remainder of the population at a rate which excludes the known high cost member's experience, resulting in a lower rate for the remainder of the population. This protects WellCare from paying higher rates on the entire population in the case that the known high cost member lapses coverage. The end result is lower reinsurance costs to WellCare and less risk transferred to the reinsurer)
- Any experience refunds, if applicable.
- Termination clauses.

RISK ANALYSIS, ASSUMPTIONS, COST ESTIMATES AND RATIONALE SUPPORTING WELLCARE'S REINSURANCE ARRANGEMENTS

- WellCare will determine whether it will consider coverage only from its incumbent carrier or whether quotes from other reinsurers will be considered for the upcoming Policy Year risk assessment. Any additional quotes may be facilitated through independent solicitation or through a broker. The decision of whether to consider additional quotes may be driven by changes in the reinsurance market, corporate risk capacity, satisfaction with current carrier, or other drivers.
- A separate in-house rate development is conducted by WellCare's Actuarial Services team to determine reasonable ranges for reinsurance premium rates. This pricing uses WellCare-specific data, but may also utilize other source data which is available such as data from consultant rate reports,

data from other state programs, marketplace trends, and other publicly-available sources.

- Some key considerations unique to reinsurance coverage are factored into the analysis. Some of these include:
  - Reinsured claims have higher volatility than the total claims that include "first-dollar" claims below the deductible. For this reason, it is sound practice to consider the credibility of a given observation and utilize multiple measurement periods when determining reinsurance rates, whenever possible.
  - Claims above a deductible exhibit a leveraged effect on the experience above the deductible. Therefore, claim trends become magnified for risk measured above the deductible. This may result in percentage rate changes that are much higher than the total claim trend. To illustrate this, suppose a member had $2,400,000 in hospital claims, and reinsurance coverage at a $2,000,000 deductible and 100% coinsurance, then the claims covered by reinsurance would be $400,000. If the same member had the same claims next year but the hospital fee schedule increased by 5%, the total claims would be $2,520,000, and the claims covered by reinsurance would be $520,000. The leveraging effect can be seen in that the total claims increased by 5%, but the claims covered by reinsurance increased by 30%. This is an important consideration when assessing the percentage rate changes proposed by the reinsurer.
  - Certain populations or events may trigger significant changes to reinsurance risk. Some of these include changes in NICU coverage or incidence rate, changes to high cost specialty drugs for hemophilia and other diseases requiring drug therapy regimens, and transplant incidence. Therefore a small change to the experience of these relatively- small subpopulations can cause significant changes in the underwritten reinsurance risk pool. Such changes are reviewed as part of the annual risk assessment process.
  - The in-house rates are compared to those produced by the reinsurer, and key variances are identified. Discussion regarding the rate development assumptions and data sources are conducted to understand the variances. Since the reinsurer may have access to additional data sources (i.e., multi-provider claims data bases, consultant models, etc.), variances in pricing are not uncommon and can often be attributed to the reinsurer's pricing information, manual rating system, and underwriting guidelines. The rates are considered acceptable once key variances are resolved with the end result of WellCare actuaries gaining a comfort level that the rates are reasonable for the marketplace.
  - Key contract terms are assessed for potential coverage to reflect any changes in Medicare or in the state's Medicaid program.
  - A senior management team typically including the Chief Financial Officer, Chief Accounting Officer, and Chief Actuary are involved in the final decision process for coverage. This incorporates high level input around financial position, rate levels, and corporate risk tolerance into the analysis. These discussions may result in proposing changes to the overall risk reinsured, including deciding the appropriate level of deductible to trigger reinsurance.
  - The final agreed-upon rates are then approved through a signed binder, amendment of necessary contract terms, and submission of contracts to the appropriate state agencies for approval.

SECTION IV.B ELIGIBILITY AND ENROLLMENT

5. Provide a comprehensive discussion of the MCO's approach to maximizing the number of members who have a relationship with a PCP, including:

- The strategy the MCO will use initially, and on an ongoing basis, to ensure PCP selection within 30 calendar days.
- Examples of successful strategies and lessons learned in encouraging PCP relationships.

(Page limit 2 pages)

MAXIMIZING THE NUMBER OF MEMBERS WHO HAVE A PCP RELATIONSHIP

As a plan solely focused on serving people in government-sponsored health care programs for more than 20 years, we have tailored our approach to support relationships between our members and their primary care providers (PCP) with the unique challenges of our membership in mind. Our strategy places a premium on member choice and helps our members make that choice in the most streamlined and efficient way possible. Our strategy also recognizes that successful member-PCP relationships require engagement from both sides, so we use similar tools of customer service and data exchange to support both members and providers in connecting.

We employ several different strategies to ensure that our members are matched with PCPs who are culturally appropriate and can meet their healthcare needs, again, with a focus on member choice. We give members multiple ways to make a proactive choice of PCP including, but not limited to:

- Selecting a PCP during the initial member welcome call
- Calling a member services representative to select a PCP
- Seeking assistance from a WellCare of Nebraska member representative in person or at one of our Welcome Rooms placed across the state
- Selecting a PCP through WellCare.com, which includes a provider search function that is built using natural language (i.e. a member can search for "heart" rather than "cardiologist") for ease of member use and to meet health literacy needs of our membership

We will reach out to all members who have not made a proactive PCP selection during enrollment within 10 business days of receiving enrollment files from the state to assist them in selecting a PCP. And, if the member still has not chosen a PCP, we will conduct auto-assignment within one month of the enrollment date.

When Members do not make a proactive choice, we deploy algorithms that take into consideration a number of factors focused on aligning members with the best PCP for their needs. Because we place a premium on existing PCP relationships, our first step is to honor any existing relationships as detailed to us in member files provided by the state or transitioning managed care organizations. Additionally, we consider family member PCP relationships, location, language and/or special or cultural needs. For instance, Native American members would be connected to the most appropriate 638 Tribal Clinic or Indian Health Service provider as their PCP if no proactive selection is made.

Our Nebraska policies and procedures on PCP assignment will address these processes, as well as detail the methods and frequency of PCP assignment reporting to MLTC. We recognize that MLTC will need to approve our assignment algorithm along with our policies and procedures.

We recognize that members can change their PCP assignment at any time, and we work with members to ensure they know of that right and to help them should they choose to exercise it.

Building Meaningful Relationships between Members and PCPs

Having a PCP selected or assigned is the first step to promoting the member-PCP relationship. We take additional steps to promote a meaningful relationship.

- Connecting with PCPs through Care Coordination
  - **Care Gap Identification:** our systems are built to flag member records if there is a gap in care including routine PCP contact.
  - **Care Management and Discharge Planning:** Our Care Management team works with assigned Members to identify and ensure completion of an integrated care plan that includes identifying appropriate appointments with the PCP.
  - **Utilization Reporting:** Monthly, we provide each of our PCPs with a list of assigned Members who had a preventable admission or re-admission, or an avoidable use of the (ED). We work with our PCPs to contact the members to address gaps in care and implement solutions to problems that resulted in the preventable admissions and avoidable ED use.

In addition, we incentivize members to attend their first PCP appointment by offering them *Healthy Behaviors Rewards* such as a gift card.

Successful Strategies for Encouraging Primary Care Providers

Not only do we engage with members to drive PCP selection, we also use our analytic capability and our Clinical HEDIS Practice Advisors (CHPAs) to drive PCP engagement of new members. WellCare's CHPAs are specially trained provider support personnel who help providers address quality of care issues in their practices. In our Kentucky affiliate, CHPAs help PCPs connect with their members (whether a member selected them or they were auto-assigned) through our "New Member" reports. Reports are generated monthly identifying new members to the provider's panel, and CHPAs distribute these reports to providers. This report gives providers an opportunity to outreach their new members and get them in for needed visits.

Also, in Kentucky, we have developed a PCP Change Request form to better ensure PCP assignment is a meaningful process. Even with the best algorithms and member education, all health plans see members seeking out providers not assigned to them. Our CHPAs promote and use the PCP Change Request form to identify members who would like to change their current PCP selection. We use claims data to obtain this information, and we pre-populate the form for these members with the member and provider information. The CHPAs ensure providers have these forms when a member who would like to change PCPs comes into their office. In 2014 we entered 4,464 PCP changes. So far in 2015, we have entered 11,929 PCP changes in an effort to maximize the member-PCP relationship and honor member selection of PCP. We will use CHPAs in these same roles in Nebraska.

Best Practice: Leveraging Community Relationships to Identify and Resolve Member Barriers

There are many potential barriers that can keep a member from engaging with their PCP. We learn about them from our community partners who assist us in better understanding our members who face a multitude of cultural and socioeconomic challenges as they interact with the health care system. Some of the common barriers our members experience include lack of reliable transportation, language barriers, poor fit between member and PCP for other cultural reasons, child care needs, concern about lost wages, and housing instability.

Through our community engagement model, Health*Connections*, we can identify the gaps in the social safety net in a given locale, anticipate how it will affect our members and provide a service or find a community service organization to meet that need. Through these partnerships, we identify and ameliorate those needs that prevent members from being able to engage with their PCP.

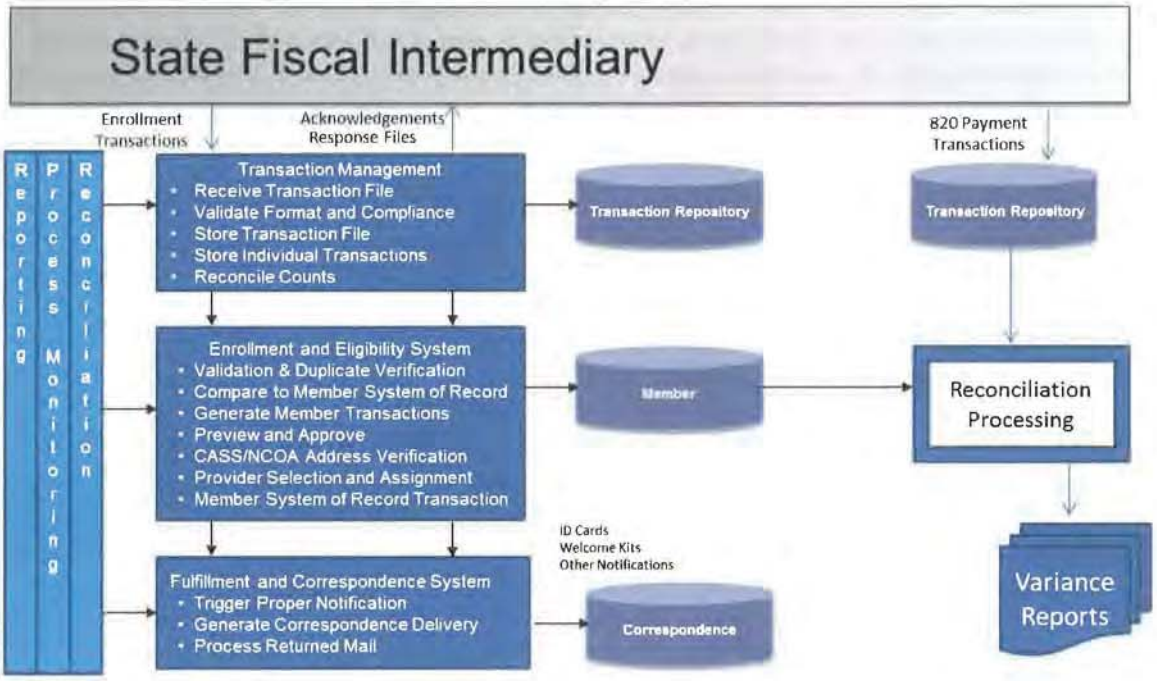
SECTION IV.B ELIGIBILITY AND ENROLLMENT

6. Describe the MCO's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records. *(Page limit 1 page)*

Utilizing MLTC's Eligibility and Enrollment Files

WellCare of Nebraska's Enrollment Eligibility System (EES) allows us to receive, process and update enrollment data daily. The system will use information transmitted by MLTC through 834 files delivered on the frequency specified by MLTC, including monthly roster and termination files. Our EES tracks and reconciles each individual transaction from receipt through membership update. Our member eligibility processes recognize MLTC as the source of truth for member eligibility and demographic data. As a result, each transaction received on the 834 files is compared to our Core Processing System (CPS) member tables. We then update our member tables to align with the information from MLTC. This information is generated and executed, ensuring that our member information accurately reflects active membership. Our member data is also reconciled on a monthly basis with capitation payment reports to ensure that payments (by rate cell) tie to our membership records. **Figure 1** shows a visual of our EES.

Figure 1



Weekly Reconciliation

As specified in the scope of work, we will reconcile the enrollment file received from the enrollment broker weekly and will provide written notification to the broker within ten calendar days of any inconsistencies noted. Likewise we will comply with notifying the MLTC within three months of any discrepancies of members for whom we received a capitation. To facilitate this process, WellCare of Nebraska will designate staff to coordinate with the Enrollment and Revenue Reconciliation teams to communicate all membership discrepancy types (including name, out-of-service-area address, date of birth, category of eligibility, cap payments, etc.).

SECTION IV.B ELIGIBILITY AND ENROLLMENT

7. Describe the interventions the MCO will use prior to seeking to disenroll a member who requests disenrollment outside the annual open enrollment period. Provide examples of scenarios in which the MCO has effectively intervened to avert disenrollment of a member or members. *(Page limit 2 pages)*

Averting Member Initiated Disenrollment

Our members are our reason for being, and we work hard to develop a trusting relationship with them. Historically, we have found that if we proactively and expeditiously address member concerns, members rarely choose to change to another MCO. Should a member request disenrollment, we have policies and procedures to ensure a smooth transition. However, we also work to mitigate member-initiated disenrollment by proactively identifying members who may have concerns and working quickly to resolve member issues.

We understand that members may disenroll from their managed care organization (MCO) without cause during the first 90 days of initial enrollment. After the first 90 days the member may only request disenrollment "for cause". Members will also be allowed to change MCOs during the annual open enrollment. Members may also request disenrollment when the state imposes the intermediate sanction specified in 42 CFR 438 702(a)(3). We recognize that disenrollment provisions apply regardless of mandatory or voluntary enrollment. After 90 days, members may disenroll for the following "for cause" reasons: member moves out of the service area, member needs related services and all related services are not available within the network, and other reasons including poor quality of care, and lack of access to services or providers.

Resolving Member Concerns to Prevent Disenrollment

We strive to provide every member with excellent service, support and access to care. If, however, a member experiences an issue and desires to disenroll, we also recognize that this process can be troubling and disruptive to the member. In response, we work closely with members to resolve concerns that may result in a request for disenrollment and take each opportunity of contact with a member experiencing difficulties to engage and resolve issues using the most appropriate intervention available, whether it is better access to treatment, education, coordination of services, or care management. As with all member interactions, we document the interventions, any outcomes and follow-up required in our system of record. We also engage with the member's PCP to collaborate on potential solutions and interventions.

MEMBER STORY

Resolving Member Concerns to Prevent Disenrollment

- A Florida Medicaid member recently filed a complaint with the state requesting disenrollment because she could not locate a rheumatologist. The member was asked to contact us for resolution prior to disenrollment. After receiving the member's grievance, we took action. We were able to find a rheumatologist in the member's area. We then called the member's PCP to confirm the referral, contacted the rheumatologist and helped the member schedule an appointment. The member was satisfied and remains enrolled with us.

Using Data Analytics to Identify and Resolve Unmet Member Needs

We run regular analytics to identify members who may be at risk of disenrolling. We use a predictive modeling based upon the member's engagement with their PCP or our call center to identify members at risk before they even seek to disenroll. For instance, we can identify members who have made several calls to member services and the time between calls to trigger an intervention. Additionally, phone interactions between our members and customer service representatives are monitored for key words that indicate a member may be at risk of disenrolling. Those key words flag the call and escalate it to a supervisor to help ensure the member concern is resolved quickly. Using both predictive modeling and

real time speech analytic capabilities provide us needed information to identify members who have concerns or unmet needs.

Members who have a concern that could potentially lead to a request for disenroll may express their concern through our formal grievance system. We encourage members to file grievances as it helps us identify issues in the system that can help us drive toward continued performance improvement. Grievances received electronically as well as those received by mail, fax, email, and through staff members, are processed by a dedicated grievance department staff. As grievances are received by our grievance department, they are logged into the grievance tracking database. We adhere to all applicable state and federal guidelines as well as accreditation standards for grievance procedures. We know often members have grievances based on a unique clinical need or situations. When this occurs, the grievance coordinators refer cases to clinical staff members for review and input. Depending on the nature of the need, the Chief Medical Officer or other clinical team members will engage with the member, their caregiver or advocate to address his or her need.

Averting Disenrollment through Community Partnerships and Mitigating Social Service Barriers

Through our CommUnity Advocacy program, WellCare of Nebraska maintains strong relationships with community partners to encourage collaboration and increased knowledge about how to navigate the healthcare system. WellCare of Nebraska identified more than 5,000 partners with whom to collaborate to divert potential transitions of members by providing information about how to navigate the health plan and benefits as well as effectively access and use social services to address barriers created by social determinants of health.

MEMBER STORY

Resolving Member Concerns to Prevent Disenrollment

- Our CommUnity Advocate in New Jersey partnered with a local care manager to help a member at risk for losing Medicaid benefits. The care manager established a relationship with the member which strengthened over time. With a series of struggles, the member and her husband nearly lost SSI benefits. The Case Manager learned about their situation and helped connect the family to several social services and Medicaid benefits. Accessing these programs helped the member avert disenrollment and continue receiving the care she needed for her advanced rheumatoid arthritis.

SECTION IV.B ELIGIBILITY AND ENROLLMENT

8. Describe the MCO'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 page)*

IDENTIFYING UNBORN INDIVIDUALS BY FIRST IDENTIFYING EXPECTANT MOTHERS

Based on our experience serving moms and babies in other states, WellCare has developed various strategies to identify unborn individuals anticipated to begin coverage at the time of their birth. This process begins with the identification of expectant mothers – both to make sure they get the care they need and to make sure we can identify the child for coverage once born.

We identify members who are pregnant through a number of methods, including state eligibility 834 file, referrals from state or community agencies, member or caregiver referrals, provider referrals, behavioral health provider referrals, the Nurse Line and crisis line referrals. We contact our members who are pregnant at least 60 days prior to their scheduled delivery date, and we allow at least two weeks postpartum for the mom to choose a PCP for her infant. In addition to the more routine methods of identifying and caring for expectant moms, WellCare of Nebraska will leverage its proprietary CommUnity Advocacy program to identify and coordinate care for expectant moms and their babies in the Heritage Health program.

A key step to identifying unborn individuals is to partner with providers effectively. We do this several ways:

- Creation of a global authorizations to cover pregnancy services and authorization for the subsequent delivery – through our authorization, our Medical Management Platform allows us to stay abreast of the member's progress through her pregnancy.
  - In high-risk pregnancies, where care management has been triggered, care coordinators are aware of the birth and work with the moms to identify a suitable PCP for her infant.
  - For other moms, our claims process triggers our awareness of the child's birth, and we begin the process of enrolling the child and communicating that information to MLTC.
- Partnering with hospitals to receive information at the time of birth. Our hospital contracts will include provisions that the hospital should notify us when one of our members gives birth. Additionally, WellCare has a robust process to partner with facilities on discharge planning, which starts at the time of admission (or before) and has tailored elements for births.

As noted above, our experience with Medicaid programs covering moms and children has informed our process in Nebraska, and we fully recognize each state has its own nuances around eligibility and enrollment of newborns, so we are eager to partner closely with MLTC to inform these processes through implementation.

Our Florida affiliate, for example, identifies newly born children through our providers and also through claims history data. We then use this information to follow up with the mom telephonically to ensure that she has selected a PCP for her child and has followed up with Florida's Division of Children and Families as she is required to do. This process has worked well for our members, and we anticipate leveraging this best practice in Nebraska.

SECTION IV.B ELIGIBILITY AND ENROLLMENT

9. Describe the MCO's approach to working with other MCOs in the event a member changes his/her MCO during ongoing operations of the program. Describe how the MCO will work with other MCOs to ensure a seamless transition and transfer of relevant information. *(Page limit 1 page)*

TRANSITIONS OF CARE: ENSURING CONTINUITY FOR MEMBERS WHEN THEY CHANGE PLANS

WellCare has spent more than 20 years coordinating care for our members under a number of different scenarios including members transitioning from fee-for-service or from another managed care organization. To ensure the least disruption possible, our transition of care policies and procedures prioritize member needs by ensuring smooth information exchange, relationship-building among MCO care managers and engaging the member through communicating about the process, the responsibilities of the MCOs, and the member's continued access to services and providers.

Transitioning Members Between MCOs

A critical step in any transition is educating the member on the process, and coordinating with the member to ensure that needs are met, and the member's care continuum is not interrupted.

For members transitioning away from WellCare, complete member records are provided to the new MCO. Those member records include the member's care plan, any relevant additional information regarding the member's physical and behavioral health needs as well as any community supports to which they have been referred in order to assure that the new MCO is equally equipped to provide continuity of care for that member. For members engaged in active telephonic or field-based care management, transmission of information is followed with engagement by a care manager as needed to facilitate continuity of the care plan and any special needs.

For members coming into WellCare from another MCO, we will incorporate information provided to us by the departing MCO or the state, conduct our own assessment and stratify the member informed by the member experience with the previous plan and current situation. We will welcome the new member with all of our new member welcome processes including the initial welcome call, mailed welcome packet and health risk screening. We will also work to ensure seamless transition of the member's primary care provider (PCP) and take every step possible to maintain that existing relationship unless the member chooses a different PCP.

Using Systems and Technology to Ensure a Seamless Transition

The information we receive from another MCO or other payer relinquishing a member is typically claims history data used for the purpose of identifying members enrolled in a care management program. We also solicit care plans and treating provider's contact information from the previous payer. We have systems that accommodate obtaining Health Risk Assessment information via an 834 enrollment file.

In Nebraska, additionally, we have identified an opportunity that will enhance information sharing which is beneficial for members transitioning into and out of different health plans. We believe the Nebraska Health Information Initiative (NeHII) plays a valuable role in the transition of care by offering access to clinical records. NeHII currently holds or accesses records from a growing share of the hospitals and providers in Nebraska. WellCare was invited to provide input to the NeHII Strategic Planning meeting on October 2, 2105 where we encouraged NeHII to allow and encourage MCOs to provide information and have access to the network. This would further smooth a member's transition, not only between MCOs, but between providers and health homes as well. This information, in machine-readable form, would aid care managers and providers and be used in population health management programs to ensure the right treatment is available at the right time.

IV.C Business Requirements

IV.C BUSINESS REQUIREMENTS

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

WELLCARE IS DESIGNED TO ENSURE COMPLIANCE WITH ALL RELEVANT LAWS AND REGULATIONS

WellCare understands and acknowledges that we must meet all relevant provisions of Part 438 of Chapter 42 of the Code of Federal Regulations and Titles 471, 477 and 482 of the Nebraska Administrative Code. We will observe and comply with all current federal and State laws related to or affecting the Contract, including any law that may be enacted during the term of the Contract. Among other things, this means we will protect members' privacy and other rights, reimburse for services and benefits in accordance with state laws, and adhere to applicable cost sharing requirements. WellCare also recognizes our responsibility to ensure that our associates and providers do the same.

WellCare affiliates are currently providing Medicaid managed care services in nine states, so we have established knowledge, infrastructure and experience with the various programmatic requirements of Part 438 of Chapter 42 of the Code of Federal Regulations. We recognize that regulations are ever-evolving and monitor rulemaking related to Part 438. As part of the implementation of our Nebraska plan, we have been reviewing relevant Nebraska state laws and regulations, including Titles 471, 477 and 482 of the Nebraska Administrative Code, to ensure that our plan operations are consistent and compliant with state programmatic requirements.

WellCare will ensure compliance through our mature Corporate Compliance Program as detailed below.

Identifying and Analyzing Applicable Laws and Regulations

In order for a compliance program to effectively monitor compliance with laws and regulations, the enterprise must first have a process to identify and analyze those laws and regulations that impact its operations.

WellCare's Compliance, Regulatory Affairs and Government Affairs/Public Policy teams each has a role in identifying and analyzing laws and regulations impacting our business and the manner in which we serve our members. In each of our state affiliates, our local Regulatory Affairs personnel track legislative and regulatory changes impacting our individual plans, and our corporate Government Affairs/Public Policy team tracks legislative and regulatory changes impacting WellCare's plans more generally, such as regulations adopted by the Centers for Medicare & Medicaid Services (CMS). Our Regulatory Affairs teams coordinate meetings with impacted functions across the WellCare enterprise to review amendments to our state contracts and other regulatory changes to ensure programmatic changes are understood and addressed in a coordinated manner. Compliance assists with analyzing rule changes as necessary and with risk assessments to help ensure programmatic changes are reflected in the appropriate policies, procedures and processes. The Compliance team also reviews and shares guidance on contractual amendments, new regulations, CMS memoranda and other guidance through a variety of means including our Regulatory Adherence Committee. This new committee was expressly established to provide us with a mechanism to identify, evaluate and help ensure proper implementation of regulatory and contractual changes that impact the manner in which we serve our members and government clients.

Ensuring Compliance with Federal and State Laws and Regulations through WellCare's Compliance Program

Our Compliance Program is intended to promote ethical conduct in all aspects of our operations and to ensure compliance by WellCare and its associates, subcontractors and providers with applicable federal and State laws, regulatory requirements and standards through:

- Written corporate policies and procedures, developed to provide guidance and internal controls on

matters affecting legal and regulatory compliance issues

- Compliance training programs, conducted to ensure that policies, procedures and related compliance concerns are clearly understood and followed by all WellCare officers, associates and directors
- Open lines of communication for WellCare associates, members and others to easily and confidentially/anonymously ask questions or report suspected violations of company policies or of legal and regulatory requirements without fear of retaliation
- Internal attestation process to ensure information provided to government agencies through RFP responses and reports is accurate, timely and complete
- Prompt investigation of reported concerns and the implementation of effective corrective action when required
- Periodic audits and routine monitoring of business operations to measure and assess WellCare's compliance with internal controls and with applicable federal and state laws, regulations and guidance
- Clear and specific disciplinary policies that address violations and promote accountability

WellCare's Compliance Program applies to WellCare and its direct and indirect subsidiaries and covers our Medicare, Medicaid and state-based programs. When required, WellCare notifies and obtains federal or state regulatory agency approval for changes to the compliance plan.

Code of Conduct and Business Ethics

The Code of Conduct and Business Ethics is the foundation of our Compliance Program. It describes WellCare's commitment to operate in accordance with the laws and regulations governing our business and accepted standards of business integrity.

Everyone in WellCare's organization must adhere to the Code at all times. Officers, associates and directors are required to acknowledge that they have reviewed the Code and will carry out their responsibilities lawfully and according to WellCare policies.

Under the Code, WellCare associates have an obligation to report suspected compliance violations. Associates are required to play an active role in preventing and eliminating fraud, waste and abuse and other program violations, and must speak up when they become aware of a possible compliance violation. The Code contains a strong non-retaliation policy on behalf of associates to encourage them to come forward if they become aware of possible compliance violations.

The Code of Conduct and Business Ethics is reviewed and approved annually by the Board of Directors. The Code is available to associates through the WellCare intranet and to the public on WellCare's website.

Policies and Procedures

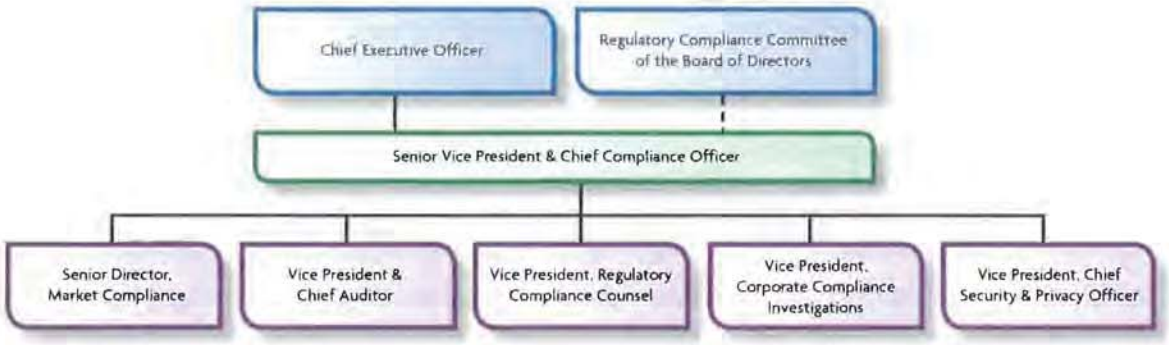
Our Compliance Program is carried out through a comprehensive system of internal policies and procedures that address day-to-day compliance risks and help reduce the prospect of fraudulent, wasteful and abusive activity by identifying and responding to specific risk areas. All corporate departments and local plans are responsible for developing written policies and procedures that address areas of compliance risk in their business units and/or markets. These policies and procedures must be reviewed by the Corporate Policy and Procedure team and provided to all affected associates. Because risk areas evolve and change over time, our policy is to review our policies and procedures not less than annually and to revise them periodically as necessary to keep them up to date with laws and practices.

Organization and Oversight

WellCare's administrative structure emphasizes the importance we place on compliance. As explained in further detail below, WellCare's Board of Directors has had a standing committee dedicated to compliance, the Regulatory Compliance Committee (RCC), since 2008. WellCare's Chief Compliance Officer (CCO) is an executive-level officer that reports directly to WellCare's Chief Executive Officer

(CEO) and the RCC. WellCare's Compliance Department is currently staffed by 136 associates dedicated to ensuring WellCare's operations are conducted with the highest level of integrity and in compliance with all laws and regulations. Please see **Figure 1** below for a high-level organizational chart for our Compliance department.

Figure 1



The Chief Compliance Officer

WellCare's CCO is an executive officer of WellCare who reports directly to WellCare's CEO and to the RCC. The CCO oversees and directs the Compliance Program throughout the organization and is responsible for ensuring that the program's goals are achieved and maintained. The CCO also is responsible for the oversight and monitoring of compliance with Medicaid and state-based programs, Medicare Advantage and Medicare Part D program requirements, compliance training and education, privacy and information security compliance, investigation of compliance and regulatory violations, and the detection and prevention of fraud, waste and abuse by members, subcontractors and providers. The CCO also serves as the point of contact for WellCare associates regarding compliance concerns or violations.

Committee Oversight and Structure

The WellCare Board of Directors is responsible for the overall organization and performance of the Compliance Program through the RCC. The RCC is currently comprised of four independent directors and meets on a quarterly basis, or more frequently as needed. The RCC reviews and evaluates reports from the CCO and independent sources and initiates actions as it deems necessary to promote the overall effectiveness of the program. Consistent with best corporate governance practices, the RCC also evaluates the results of a compliance program effectiveness assessment annually to review and assess the structure, operation and efficacy of the Compliance Program.

The Corporate Compliance Committee (CCC), established by the WellCare Board of Directors and chaired by the CCO, oversees the operations of WellCare's Compliance Program through an established program charter and serves as a resource to the CCO. The CCC is comprised of senior executives throughout the company. The principal purpose of the CCC is to ensure the development and implementation of an effective corporate ethics and compliance program for all WellCare lines of business, including Medicaid and state-based programs, Medicare Advantage and Medicare Part D, and to oversee the activities of the WellCare Compliance department. In addition, the CCC is tasked, with assistance from the CCO and the Compliance department, with advising, reporting to and supporting the RCC in performing its responsibilities. Generally, but at least three times per year, the CCC through the CCO will update the RCC regarding the activities and status of the Compliance Program, including issues identified, investigated and resolved through the Compliance Program. Additional updates are provided as necessary.

Compliance Liaisons and Market Compliance Oversight Committees

WellCare recognizes that in order for its Compliance Program to be truly effective it must be implemented at the local level as well as the corporate level. Our associates located in Nebraska will be the best situated to recognize compliance risks that may arise locally. Therefore, in our Medicaid markets we have established the position of Compliance Liaison (also known as a Director of Market Compliance) and/or local Market Compliance Oversight Committees. We anticipate both hiring a Compliance Liaison and establishing a Market Compliance Oversight Committee in Nebraska.

The Compliance Liaison assists the CCO with the implementation of policies, procedures, and practices designed to ensure compliance with the requirements set forth in applicable federal and State laws, regulations, health care program requirements and plan contracts. The Compliance Liaison serves as the contact for the CCO for compliance and ethics activities in WellCare's principal plans. The Compliance Liaison also functions as the local contact for the Compliance department's functional units and serves as a local resource for identifying, tracking, mitigating and reporting on operational compliance risks.

Market Compliance Oversight Committees provide local Compliance Program oversight, risk assessment and business engagement, and provide a forum for open communication and coordination of local and corporate compliance matters, regulatory notices and changes. Each Market Compliance Oversight Committee is chaired by the local Compliance Liaison and consists of the plan President and leaders of Regulatory Affairs, Government Affairs, Network Management, Provider Operations, Provider Relations, Sales, Operations, Health Services, Human Resources and any other members as the Market Compliance Oversight Committee may designate. Through the Market Compliance Oversight Committee, visibility is provided to the CCO and Corporate Compliance staff on market compliance concerns and day to day activities in the markets.

The Compliance Department

The Compliance department staff has responsibility for the oversight of WellCare's compliance performance, including risk assessment, compliance policy development, education, investigations of alleged violations, oversight and response to incidents of non-compliance and auditing. The department includes units concentrating on compliance investigations, policies and training; regulatory compliance; HIPAA privacy and security; record and information management and our Compliance Liaisons.

Training and Education

WellCare conducts mandatory compliance training upon hire and annually for all associates, officers and directors. All associates are required to take over 10 hours of compliance training annually. The program includes certification to the Code, general compliance training, which includes training on fraud, waste and abuse, as well as mandatory courses on fraud, waste and abuse and HIPAA privacy and security. Associates who are responsible for specific functions or services related to Medicare and Medicaid business areas receive additional specialized training on issues which may pose unique compliance risks, and many associates are required to take more based on their job functions. Completion of compliance training is tracked through an automated system. The system sends reminders to associates and alerts associates' supervisors as training due dates approach. Failure to complete this training in a timely fashion results in disciplinary action as documented in our Associate Handbook.

WellCare also oversees delegated entities to ensure that their personnel performing work for us or interacting with our members receive compliance training and guidance and have reporting mechanisms to respond to suspected or identified fraud, waste or abuse.

WellCare maintains and updates, as appropriate, the curricula of general and specialized compliance training programs to educate all impacted parties on the requirements of federal and State laws, regulations and guidance and to detect possible violations.

Compliance Reporting and Investigations

WellCare's compliance reporting and inquiry system assures efficient and confidential communication between and amongst the Compliance department, the CCO, associates, officers and directors, agents, first tier, downstream, and related entities, members and other company stakeholders.

WellCare's Compliance Hotline and web portal are central components of WellCare's compliance reporting and inquiry system. By accessing the Compliance Hotline or web portal, associates and others can report compliance program violations at any time. Hotline calls and web entries are reviewed and addressed by Compliance department staff with the assistance of department or area managers (e.g., Legal, Human Resources and Finance) as necessary. Consistent with compliance best practices, the web portal is hosted by an independent third party vendor, ensuring complete anonymity when desired by the reporter.

Associates are obligated to report actual or suspected violations of law or of the Code or other WellCare policies. The availability of the Hotline and web portal is publicized to the WellCare community through the Code, office posters and our intranet. Hotline activity is reviewed regularly by the CCC. Callers who report violations may remain anonymous upon their request.

Associates also may raise compliance questions with or report a suspected violation to:

- Their immediate supervisor
- The Human Resources department
- The Chief Compliance Officer
- Compliance Liaisons
- The Chief Legal Officer
- The Chief Auditor

Matters reported through the Compliance Hotline or other communication sources that suggest violations of our policies, federal or State health care program requirements or applicable laws are investigated promptly to determine their veracity and significance. Depending on the nature of the issue, an investigation may be conducted with the assistance of the Legal department or outside counsel.

WellCare maintains a non-retaliation policy strictly prohibiting retaliation against any individual who in good faith reports a possible ethics violation or compliance concern.

WellCare reports suspected or confirmed cases of fraud, waste and abuse, violations of the False Claims Act or potential fraud or misconduct to appropriate law enforcement agencies, the Centers for Medicare & Medicaid Services ("CMS") or its designee and/or other State or federal government agencies as described in WellCare's policy on fraud, waste and abuse in accordance with applicable program requirements.

Internal Attestations

WellCare is committed to submitting fair, truthful, accurate and complete bids to participate in Medicaid programs and other federal and state health care programs. We have implemented processes and procedures designed to ensure the integrity and accuracy of our bids. As part of our bid process, each WellCare associate, consultant and/or contractor who submits material information or data to be included in our bid, must certify that the information he or she submitted is fair, accurate, truthful and complete. These attestations are collected and tracked through Compliance 360, a compliance and risk management system.

WellCare recognizes that government agencies rely on the information it provides through the lives of its contracts and has adopted other specific policies and procedures to ensure report integrity. These policies and procedures ensure that reports are appropriately reviewed, validated, certified and approved prior to

their submission to any regulatory agency. The purpose of these policies and procedures is to help ensure that all submissions are accurate, complete, timely submitted, compliant and in accordance with all governing contractual provisions and the underlying laws and other requirements.

Auditing and Oversight

The Corporate Audit & Oversight department is comprised of our Enterprise Risk Management, Internal Audit, Compliance Oversight, and Delegation Oversight teams.

The Chief Auditor is responsible for leading Corporate Audit & Oversight and reports functionally to the Audit and Finance Committee of WellCare's Board of Directors and has a dotted line reporting relationship to both WellCare's Chief Financial Officer and Chief Compliance Officer. This reporting relationship is intended to promote the independence of Corporate Audit & Oversight, comprehensive audit coverage, and appropriate coordination with the other activities of management and our independent external auditor. The CCO also provides functional leadership to the Corporate Audit & Oversight team activities that focus on WellCare's compliance with State and federal laws and regulations.

Audits may be conducted as part of an investigation of a reported issue or as a proactive means of monitoring regulatory compliance in areas of actual or potential risk. Specific to compliance, Corporate Audit & Oversight provides independent, objective assurance designed to add value and improve WellCare's operations by bringing a systematic and disciplined approach to evaluating the effectiveness of our control, risk management, and compliance processes. Through audit procedures including observation, inquiry and sample testing; Internal Audit's evaluations are designed to provide reasonable assurance that our network of control, risk management and compliance processes, as designed and represented by management, are in all material respects adequate and functioning in a manner to help ensure the following:

- Significant financial, managerial, and operating information is accurate, reliable, and timely
- Significant risks are appropriately identified and managed
- WellCare and its associates comply with corporate, State, federal and regulatory requirements including applicable policies, standards, procedures, contracts, laws and regulations

Corporate Audit & Oversight also provides senior management with reasonable assurances that WellCare remains compliant with State and federal guidelines by supporting each functional business area with compliance enforcement through monitoring, oversight, and appropriate response to incidents.

Corporate Audit & Oversight issues formal reports that identify opportunities to improve management controls and compliance. Audit reports are distributed to the Audit and Finance Committee of the Board of Directors. Department management and senior leadership, including the CCO, also receive the audit reports. Management's action plans (MAPs) to mitigate identified risks are outlined in the report. Corporate Audit & Oversight monitors MAPs to completion.

In addition to our internal audits, under our Corporate Integrity Agreement, which is discussed in greater detail in our response to Question 3, an independent review organization (IRO) reviews and analyzes a selection of bid submissions each year. Among other things, the IRO assesses the accuracy and completeness of the select bids and produces recommendations aimed at continuously improving WellCare's bid submission systems and processes.

Compliance Program Enforcement

If an investigation, regulatory audit or monitoring process identifies a compliance issue, the Compliance department works closely with the affected area or department to promptly resolve the issue and take necessary corrective action, including timely and appropriate disciplinary action.

Discipline

WellCare maintains a strict disciplinary policy for compliance violations. Individuals who have violated laws, regulations, CMS and/or State guidance or WellCare policies are subject to disciplinary action, up to and including termination of employment and, where appropriate, potential referral for criminal prosecution. Likewise, such violations by subcontractors may result in the termination of their contractual relationship with WellCare.

Screening for Excluded Parties

WellCare, through a third party vendor, screens current and new associates, contractors, sales representatives and agents against the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities, the General Service Administration's System for Award Management and applicable State exclusion lists. WellCare will not hire or retain an associate, contractor, sales representative or agent who is excluded, debarred or suspended from participating in federally funded programs. Health care providers are also screened against these lists using an internal process.

Detecting and Preventing Fraud, Waste and Abuse by Members, Subcontractors and Providers

WellCare's Special Investigation Unit (SIU) is responsible for the detection, prevention, investigation, reporting, correction and deterrence of fraud, waste and abuse by members, subcontractors and providers. The SIU reports to the CCO and is charged with implementing our Fraud, Waste and Abuse Plan. Suspicions of fraud, waste or abuse can be reported to the SIU anonymously through a designated SIU Hotline or electronic communication. More detailed information regarding our SIU is included in our response to Question 93 of this RFP.

Information Security and Privacy Office

The purpose of the WellCare Information Security and Privacy Office is to manage privacy, security, and records and information management (RIM) compliance requirements. Privacy and security is managed in accordance with the Health Insurance Portability and Accountability Act (HIPAA), as amended to date including by the Health Information Technology for Economic and Clinical Health (HITECH) Act, HIPAA's implementing regulations and State requirements. RIM is managed in accordance with the generally accepted recordkeeping principles set forth by ARMA International.

The mission of the WellCare Information Security and Privacy Office is to serve as a central resource for the privacy, security, and retention of member data and company records and to provide leadership in the development of programs and practices to meet relevant requirements and standards. The Information Security and Privacy Office is responsible for ensuring our policies around the protection of protected health information (PHI) are consistent with federal and State legislation. The major roles of the Information Security and Privacy Office include:

- Development, implementation and on-going management of WellCare's Information Security, Privacy, and RIM Compliance Program and governance process
- Oversight of development and monitoring of information security, privacy, and RIM compliance policies and procedures
- Development and monitoring of information security, privacy, and RIM compliance education and training programs
- Development and implementation of effective lines of information security, privacy, and RIM Compliance Program communications and reporting mechanisms
- Development and implementation of appropriate oversight committees and/or procedures to enforce sanctions and disciplinary actions for violations of information security, privacy, and RIM regulations or policies
- Monitoring and auditing for ongoing compliance

- Investigation of reported and detected non-compliance incidents and development of corrective action initiatives

The development, implementation and maintenance of organizational procedures in support of corporate information security and privacy policies are the responsibility of covered departments and business areas. Likewise, ongoing operational compliance is a department/business area responsibility. The Information Security and Privacy Office monitors compliance activities, advises on compliance concerns, investigates potential areas of noncompliance and reports on compliance issues.

IV.C BUSINESS REQUIREMENTS

11. Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance. *(Page limit 1 page, excluding copy of COA)*

HOW WELLCARE OF NEBRASKA MEETS THE FEDERAL DEFINITION OF AN MCO

The Code of Federal Regulations [42 C.F.R. § 438.2] defines a managed care organization (MCO) as either a federally-qualified HMO or an entity that (A) meets prescribed advance directives requirements, (B) "[m]akes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity" and (C) meets certain solvency standards.

While WellCare of Nebraska is not a federally-qualified HMO, it will meet the federal definition of an MCO as an entity that meets the conditions of 42 C.F.R. § 438.2(2) summarized above.

A. Advance Directive Requirements

WellCare maintains written policies and procedures regarding advance directives with respect to adults receiving care through our plans. Among other items, we require that information regarding advance directives be included in member handbooks and that a member's advance directive be maintained in his or her medical record. The advance directive information in our member handbooks explains the member's rights to make decisions relating to his or her medical care.

WellCare also recognizes the need to educate its staff and its providers regarding advance directives. WellCare includes education regarding advance directives as part of its ongoing training of relevant staff. WellCare also includes in its provider handbook information for providers regarding advance directives and their responsibilities relating to advance directives.

B. Accessibility

Our goal is to maintain a provider network that makes services available to our Medicaid members in excess of required access and availability standards where possible. Our provider networking team monitors the network on a continuous basis to identify any gaps in access and availability and seeks to recruit additional providers as may be necessary. Where there are gaps, we seek to enter single case agreements to ensure our members have access to all medically necessary services. In this way, WellCare ensures that the services its network provides to its Medicaid members are as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the areas served by WellCare's plans.

C. Solvency

As demonstrated by the financial statements submitted for the Corporate Overview of this response, WellCare is an established and financially strong company with sufficient resources to support Medicaid operations in Nebraska. WellCare will transfer to WellCare of Nebraska sufficient capital to meet statutory minimum levels and risk-based capital requirements and, more importantly, to ensure WellCare of Nebraska is able to operate without becoming insolvent. WellCare monitors compliance with the minimum capital requirements on a quarterly basis and to the extent additional capital contributions are needed, WellCare will infuse capital to maintain compliance.

CERTIFICATE OF AUTHORITY

Please find attached as **Attachment 11a_Certificate of Authority Attestation** WellCare of Nebraska's attestation relating to its Certificate of Authority.

Certificate of Authority Attestation

This attestation is provided pursuant to Section IV(C)(3) of Request for Proposal 5151 Z1 issued by the State of Nebraska, Administrative Services, Materiel Division, State Purchasing Bureau, on October 21, 2015. WellCare of Nebraska, Inc. ("WellCare of Nebraska") hereby attests that it will obtain a Certificate of Authority to transact the business of health insurance in Nebraska as a health maintenance organization prior to executing a contract with MLTC. WellCare of Nebraska further attests that it submitted its application for a Certificate of Authority on November 6, 2015.

WELLCARE OF NEBRASKA, INC.

By: David T. Reynolds

David T. Reynolds, President

IV.C BUSINESS REQUIREMENTS

12. Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6 *(Page limit 3 pages)*

PARTNERSHIP: A CORE VALUE OF WELLCARE THAT DRIVES OUR APPROACH TO COLLABORATION

WellCare is guided by four core values: Accountability, Integrity, Partnership and Teamwork. The value of Partnership underscores our approach to building collaborative working relationships across the array of stakeholders within each of the states that we serve. In Nebraska, we have spent the past year working to form collaborative partnerships meeting with more than 100 stakeholder organizations. This investment has allowed us to learn about existing challenges and opportunities and develop strategies for collaborating on large-scale initiative as well as addressing individual member needs.

In addition to partnering directly with agencies and organizations, WellCare's commitment to partnership is supported by our practice and commitment to:

- Hire locally and place individuals in the communities in which our members live and work
- Have a physical presence throughout the state, with offices in Lincoln, Omaha, Kearney, Scottsbluff and Norfolk from which to engage and collaborate with all stakeholder groups
- Designate points of contact for collaboration with entities and programs that serve our members

FORMAL COLLABORATION: DEFINING PROCESSES AND PROCEDURES AND DESIGNATING POINTS OF CONTACT

In addition to the natural relationship building that occurs as a result of our hiring, physical presence and designated points of contact practices, we will also develop formal collaboration processes and procedures with several key stakeholder partners serving Heritage Health members.

Division of Behavioral Health Funded Programs

To inform our approach to working with programs funded through the Division of Behavioral Health (DBH), we met with Division of Behavioral Health leadership, two of the state's Regional Behavioral Health Authorities, several stakeholders engaged in the Behavioral Health system including the Nebraska Association of Behavioral Health Organizations (NABHO) and Children and Family Coalition of Nebraska, for example. We also met with providers engaged in the system such as Centerpointe. Because Behavioral Health funded programs tend to work both with Medicaid members and individuals without health coverage and cared for through state and federal programs, WellCare recognizes the critical importance of alignment among payer sources to build a sustainable continuum of care. Some select strategies we will bring to this endeavor include:

- Dedicated behavioral health field-based and telephonic behavioral health care managers who will work across agencies as needed to coordinate care for members with high levels of need, such as members discharging from state psychiatric hospitals or coming out of incarceration
- Clinical Liaison positions to assist, as needed, organizations already providing care coordination for members to prevent duplication of efforts
- Collaborate and on-going engagement between our local Behavioral Health clinical and executive leadership and NABHO including attendance at their meetings as requested
- Collaborate with Regional Behavioral Health Authorities with field-based staff in markets across the state to participate in community-based councils or other stakeholder engagement opportunities
- Representation of Behavioral Health funded programs on our provider and member advisory committees, as well as other quality committees

- Development of a Behavioral Health Advisory Subcommittee of the Provider Advisory Committee with regular and formal interaction and feedback opportunities

Division of Children and Family Services funded programs

To inform our approach to working with programs funded through the Division of Children and Family (DCFS) Services funded programs, we met with several of the largest stakeholders in that system including Boys Town, the Children and Family Coalition of Nebraska, Children's Hospital and Medical Center in Omaha, Appleseed, the Child Guidance Center and others. Nebraska's challenge of having the highest rate of children in foster care, including high rates of children in out-of-home or residential placement is a unique one for managed care organizations that requires a unique set of solutions and a robust approach to collaboration and partnership. ***Because of this, we are proposing a dedicated Foster Care Care Management team with care management staff specially trained in the unique behavioral, physical, pharmacy and social needs of foster children and in working with DCFS, the courts and other advocates in the best interest of foster care children.*** Other strategies to collaborate with DCFS-funded programs include:

- Conducting clinical "Grand Rounds" on a regular schedule with DCFS representatives to discuss challenging cases with an intense focus on moving children into community-based services
- Having care managers who can work with the state's Bridge to Independence Program for Transition Age Youth to ensure our members achieve and maintain independence
- Collaborate with MLTC and DCFS through examination of data analytics to identify best practices and implement system of care principles and services to help reduce the number of youth in out of home placement
- Participate in all DCFS stakeholder and community-based meetings and events in Nebraska urban, rural and frontier communities through our staff members located throughout the state

Division of Developmental Disabilities programs

Through our meetings with the ARC of Nebraska and leadership of the Division of Developmental Disabilities (DDD) within the Department of Health & Human Services (DHHS), we have been building our understanding of the state's developmentally disabled population and the services provided to them. We recognize that our Heritage Health membership will include individuals with developmental disabilities and, while we won't manage their home and community based waiver or institutional services, we will be helping to coordinate care for various behavioral and physical health care services. Our strategies to collaborate with these programs include:

- Working with Beatrice State Developmental Center as requested for members transitioning out of institutional care who have co-morbid physical and/or behavioral health needs
- Training care managers on the unique needs of individuals with developmental disabilities
- Having Clinical Liaison positions to assist, as needed, organizations already providing care coordination for members to prevent duplication of efforts
- Engaging in formal council meetings with ARC and DDD as invited

Nebraska Department of Education Early Development Network

One of our early meetings in Nebraska was with the Buffet Early Childhood Institute at the University Of Nebraska in Omaha where we learned about the array of initiatives under way in the state to promote healthy development in the early stages of children's lives. Our care management model, as well as partnerships with providers, is built to help rapidly identify children who can benefit from early intervention for special health conditions that can affect their development. Other strategies to work with the Nebraska Department of Education Early Development Network (EDN) include:

- Robust promotion and monitoring of the EPSDT periodicity schedule and guidelines with our provider offices and members to ensure children are identified and referred to EDN appropriately
- Developmental of formal referral process within our care management program should a member appear eligible for EDN services
- Ideally, we would like to develop a reciprocal relationship between EDN and WellCare so members engaged in either or both programs receive unduplicated but thorough coordination services
- Training of member services and community advocacy staff of EDN's offerings
- Inclusion of EDN as a resource in the member handbook, on our member website and in other materials as appropriate

Community Agencies (i.e. Areas Agencies on Aging and League of Human Dignity Waiver Offices)

Through our Health*Connections* model, we have been engaging in Nebraska for more than a year, including meeting with a broad array of Community Agencies including, but not limited to Community Action Agencies, Area Agencies of Aging, Clyde Malone Community Health Center, Sienna Francis House and several others. We have awarded nearly $10,000 in micro-grants to agencies focused on programs that address social determinants of health for our members such as homelessness, food insecurity, and behavioral health needs. Strategies we use to further collaborate with community agencies include, but are not limited to:

- Establish Health*Connections* Councils in communities across the state. These Councils are community-based planning councils that focus on issues affecting the social safety net and its viability and sustainability, including health and treatment disparities.
- Develop Business Associate Agreements with organizations to formalize the referral process for members, coordinate care and specifically track outcomes.
- Populate our exclusive database of community resources (we already have about 5,000 entries for Nebraska in our database).
- Implement our CommUnity Assistance Line and promote it within our organization to assist members and with our agency partners to help connect members to social services.
- Conduct and or attend periodic meetings for various agencies and advocacy groups including the National Association of Area Agencies on Aging (n4a).

Office of Probation

WellCare has been following closely the discussions about care for individuals coming out of the prison system, particularly as it relates to behavioral health. The L.R.295 Interim Study has highlighted ongoing challenges of working with this population. Given the nature of transient eligibility for people engaged in the penal system, it's imperative that MCOs work closely with Probation and other stakeholders in that system to understand triggers for eligibility and ineligibility, care needs and resources available. Some strategies include:

- Train WellCare associates on the unique needs of members coming out of the penal system
- Partner with the Office of Probation and others who work with this population on our CommUnity assistance line to help connect members with social services to strengthen their transition
- Include representatives from the Office of Probation in stakeholder engagement opportunities

IV.C BUSINESS REQUIREMENTS

13. Describe if any of the MCO's 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 page)*

WELLCARE'S MEDICAID ACCREDITATIONS

WellCare is committed to continuous quality improvement both in our own internal operations as well as in the care delivered through our provider networks. Of our eight currently accredited Medicaid plans, two have achieved an NCQA status of Commendable, demonstrating our commitment to holistic, patient-centered, high-quality care to our members. To date, WellCare has been successful ineach of its attempts to gain accreditation for its Medicaid plans. **Figure 2** below shows our current accreditations.

Figure 2

PLAN	STATE	CURRENT ACCREDITATION STATUS
WellCare of Georgia, Inc.	Georgia	Commendable
WellCare of New York, Inc.	New York	Commendable
Harmony Health Plan of Illinois, Inc.	Illinois	Accredited
Missouri Care, Incorporated	Missouri	Accredited
'Ohana Health Plan, Inc.	Hawaii	Accredited
WellCare of Florida, Inc.	Florida	Accredited
WellCare of Kentucky, Inc.	Kentucky	Accredited
WellCare of South Carolina, Inc.	South Carolina	Accredited

Our ninth Medicaid plan operates in the state of New Jersey. Our New Jersey plan is currently deploying our established quality infrastructure locally in order to start the accreditation process. It is expected to achieve NCQA accreditation in 2016.

As outlined in the RFP, WellCare of Nebraska will initiate the NCQA accreditation process as soon after the contract's award date as allowed by NCQA and will achieve NCQA accreditation within 18 months of the contract award. WellCare already holds a corporate NCQA certification for the centralized functions of credentialing, utilization management, case management, disease management and appeals. These centralized functions apply to all of WellCare's plans, including WellCare of Nebraska.

WellCare's corporate NCQA Accreditation team will bring its experience and expertise to the accreditation process for WellCare of Nebraska. However, WellCare recognizes that each state is unique, with its own membership, culture and practices and does not believe that a "one size fits all" approach is best for serving members. The NCQA Accreditation team works collaboratively with each affiliate's local leadership to help the plan attain and maintain accreditation in the manner best suited for that state and their local members. Among other functions, the team provides guidance on quality measures, helps to ensure plans meet or exceed accreditation standards and audits files from internal departments such as Utilization Management, Case Management, Appeals and Pharmacy to identify areas of opportunity to improve accreditation scores. In addition, each plan designs interventions appropriate for its populations in order to improve the quality of care received by members and thereby increase its HEDIS scores. WellCare also partners with external NCQA consultants to hold mock NCQA audits and summits, in which we review all plan documentation and discuss methods for meeting and exceeding accreditation standards.

IV.C BUSINESS REQUIREMENTS

14. If applicable, describe any restriction of coverage for counseling or referral services the MCO is required to provide because of moral or religious obligation. Describe how the MCO will provide members with access to those services. *(Page limit 1 page)*

NO RESTRICTION ON COVERAGE FOR COUNSELING OR REFERRAL SERVICES

WellCare will not impose any restriction of coverage for counseling or referral services it is required to provide because of moral or religious obligation.

IV.D STAFFING REQUIREMENTS

15. 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.

(3 Page limit)

EXPERTISE IN GOVERNMENT HEALTH CARE PROGRAMS DRIVING OUR NEBRASKA APPROACH

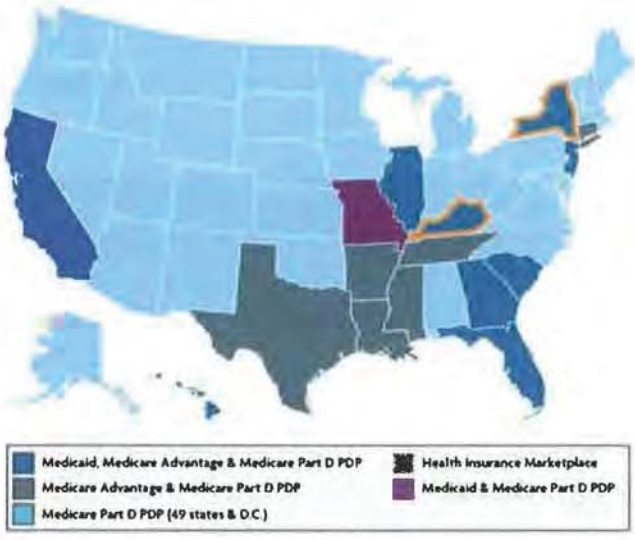
From a structural perspective, WellCare's success is founded on our local approach. We establish a state-based workforce to maximize accessibility for our members, providers, and our government clients. We then complement the local team with support through our robust corporate shared services organization, including claims processing, call center administration and information systems. Through substantial demonstrated experience gained through operations of WellCare's Medicaid footprint, WellCare of Nebraska is well-positioned to deliver on its contractual commitments to the State of Nebraska.

Lines of Business: A Focused Experience

Figure 1

Company Snapshot

OUR PRESENCE



Data is per the last reported quarter ending June 30, 2015
All numbers are approximated
Updated September 18, 2015

Founded in 1985 in Tampa, Fla.:
- Serving 3.8 million members nationwide.
- 339,000 contracted health care providers.
- 70,000 contracted pharmacies.

Serving 2.4 million Medicaid members, including:
- Aged, Blind and Disabled (ABD).
- Children's Health Insurance Program (CHIP).
- Family Health Plus (FHP).
- Supplemental Security Income (SSI).
- Temporary Assistance for Needy Families (TANF).

Serving 1.4 million Medicare members, including:
- 349,000 Medicare Advantage members.
- 1 million Prescription Drug Plan (PDP) members.

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid).
- Managed Long Term Care (MLTC).

Spearheading efforts to sustain the social safety net:
- The WellCare Community Foundation.
- Advocacy Programs.
- Creation of Public-Private Partnerships.

Significant contributor to the national economy:
- A FORTUNE 500 and Barron's 500 company.
- 6,600 associates nationwide.
- Offices in all states where the company provides managed care.

We have more than 20 years of experience focused on economically disadvantaged populations and government-sponsored health care. (**Figure 1**)WellCare's specialized focus in government-sponsored health care, and particularly in Medicaid, is unique and remains at the heart of what we do. Our technical expertise in product development, administrative processing, care management, and information technology systems and infrastructure is focused on providing precisely the types of services sought for Nebraska's Heritage Health program. The following shows our lines of business and demonstrates the depth and breadth of our government-sponsored health care program experience and capabilities:

- **Medicaid**
  - We operate Medicaid plans in nine states: Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, New Jersey, New York and South Carolina
  - We provide patient-centered managed care services to 2.4 million Medicaid members across the full spectrum of eligibility groups including, but not limited to, Aged, Blind and Disabled (ABD), those in home and community based services (HCBS) waivers, foster care, Children's Health Insurance Programs (CHIP), Temporary Assistance to Needy Families (TANF), supplemental security income (SSI), and long-term services and supports (LTSS) populations
- **Medicare**
  - We serve 1 million Medicare Part D members
  - We serve 349,000 Medicare Advantage members. Over one-half of our Medicare members are dually eligible
- **Insurance Marketplace:** We also offer marketplace products in Kentucky and New York.

Number of employees and office locations

Through our extensive experience, we have built a team of associates who put the needs of our members at the forefront of our planning and operational execution. ***We have 6,600 associates serving our members across our entire enterprise (Figure 2).*** These associates are carefully selected and rigorously trained to meet the complex needs of our members. The table below illustrates our commitment to offering a locally-based and staffed plan in each market. Each local plan has its own organizational structure and accountabilities and is supported by a corporate structure that is closely aligned. The size and need of the populations being served dictates the numbers of associates and regional offices or Welcome Rooms that we have dispersed across the state. The physical geography of the state coupled with the scope of our plan (statewide or regional) are also critical factors in the numbers of offices we locate within each state. We believe that "brick and mortar" accessibility for our members is instrumental in our being able to meet their needs and address their concerns.

Figure 2

WellCare Locations			
WellCare Medicaid Market	**Main Headquarters Location**	**Number of Additional Support Offices**	**Number of Staff Located in the Market**
Florida	Tampa, Florida	19	534
Georgia	Atlanta, Georgia	4	305
Hawai'i	Kapolei, Hawai'i	3	210
Illinois	Chicago, Illinois	0	110
Kentucky	Louisville, Kentucky	6	230
Missouri	Columbia, Missouri	1	95
New Jersey	Newark, New Jersey	0	130
New York	New York, City	16	670
South Carolina	Columbia, South Carolina	1	60
WellCare's total number of associates for all lines of business in all locations is 6,000.			

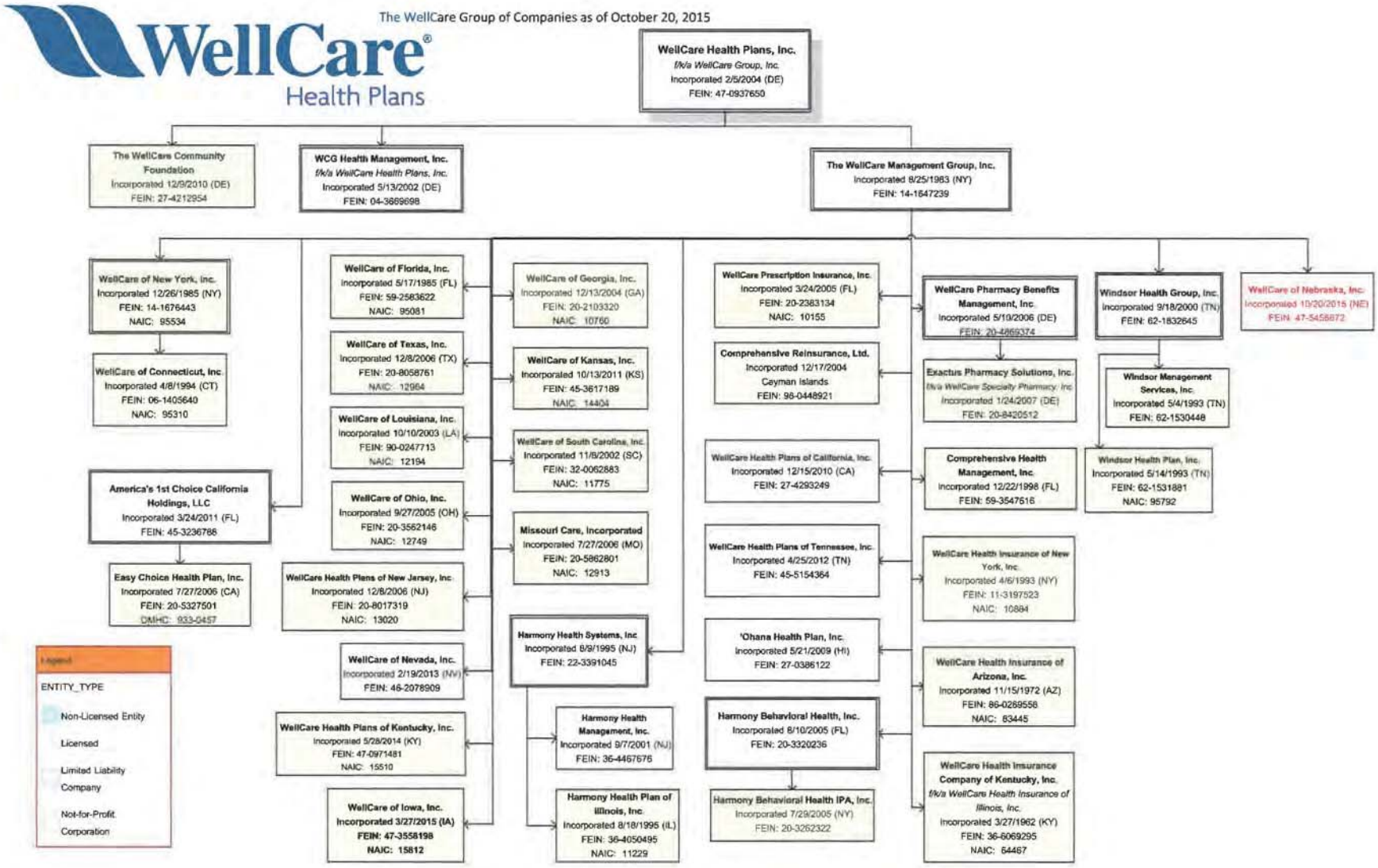
WellCare's main headquarters is located at 8725 Henderson Road in Tampa, Florida. Primary plan operations for WellCare of Nebraska, Inc. will be conducted in Nebraska. We believe that a local presence is the key to both successful implementation and ongoing operations but more importantly, local service to our members and providers has a positive impact on quality and availability of member care.

As you will see in the enclosed bid proposal, we will maintain five locations throughout Nebraska employing highly engaged, locally-based clinical services, community outreach, quality management, compliance, and provider relations staff. Our Nebraska office is currently at 1299 Farnam St., Suite 300 in Omaha. Should we be awarded a Heritage Health contract, we would locate our Nebraska headquarters in Lincoln and have Welcome Rooms in Omaha, Kearney, Norfolk and Scottsbluff.

Our Nebraska staff members will be dedicated exclusively to caring for WellCare of Nebraska members and meeting the requirements of the contract. We will develop a diverse workforce that meets the needs of the populations we serve. Our local operations will be supported by corporately-supplied resources and shared service operations which provide scale, eliminate redundancy and offer added security and support, which will be particularly important in the months leading up to the anticipated start date and throughout the first year of implementation. With our scalable infrastructure, government programs competency and strong community linkages, we are prepared and uniquely positioned to serve Medicaid members throughout the state. This model enables us to best serve our members but also provides a direct economic impact to the state of Nebraska through salaries and facility costs.

Parent Organization and affiliates

As is common in the industry, WellCare consolidates its core operations in one management company – Comprehensive Health Management, Inc. (CHMI). On behalf of the WellCare group of companies, CHMI employs all of our associates, including those based locally in the states in which we operate. CHMI also holds leases to all real estate and/or office space, owns the personal property, and maintains the key vendor contracts (e.g., information technology systems, pharmacy benefit manager) for the enterprise. The CHMI management services structure ensures effective and appropriate decision-making with a span of control that aligns scope of authority with responsibilities as well as accountability. WellCare's organizational structure is reflected on the attached organizational chart (**Attachment 15_Organizational Chart**).


WellCare Health Plans
The WellCare Group of Companies as of October 20, 2015
WellCare Health Plans, Inc.
f/k/a WellCare Group, Inc.
Incorporated 2/5/2004 (DE)
FEIN: 47-0937650
The WellCare Community Foundation
Incorporated 12/9/2010 (DE)
FEIN: 27-4212954
WCG Health Management, Inc.
f/k/a WellCare Health Plans, Inc.
Incorporated 5/13/2002 (DE)
FEIN: 04-3669698
The WellCare Management Group, Inc.
Incorporated 8/25/1983 (NY)
FEIN: 14-1647239
WellCare of New York, Inc.
Incorporated 12/26/1985 (NY)
FEIN: 14-1676443
NAIC: 95534
WellCare of Connecticut, Inc.
Incorporated 4/8/1994 (CT)
FEIN: 06-1405640
NAIC: 95310
America's 1st Choice California Holdings, LLC
Incorporated 3/24/2011 (FL)
FEIN: 45-3236788
Easy Choice Health Plan, Inc.
Incorporated 7/27/2006 (CA)
FEIN: 20-5327501
OMHC: 933-0457
WellCare of Florida, Inc.
Incorporated 5/17/1985 (FL)
FEIN: 59-2583622
NAIC: 95081
WellCare of Texas, Inc.
Incorporated 12/8/2006 (TX)
FEIN: 20-8058761
NAIC: 12964
WellCare of Louisiana, Inc.
Incorporated 10/10/2003 (LA)
FEIN: 90-0247713
NAIC: 12194
WellCare of Ohio, Inc.
Incorporated 9/27/2005 (OH)
FEIN: 20-3562146
NAIC: 12749
WellCare Health Plans of New Jersey, Inc.
Incorporated 12/8/2006 (NJ)
FEIN: 20-8017319
NAIC: 13020
WellCare of Nevada, Inc.
Incorporated 2/19/2013 (NV)
FEIN: 46-2078909
WellCare Health Plans of Kentucky, Inc.
Incorporated 5/28/2014 (KY)
FEIN: 47-0971481
NAIC: 15510
WellCare of Iowa, Inc.
Incorporated 3/27/2015 (IA)
FEIN: 47-3558198
NAIC: 15812
WellCare of Georgia, Inc.
Incorporated 12/13/2004 (GA)
FEIN: 20-2103320
NAIC: 10760
WellCare of Kansas, Inc.
Incorporated 10/13/2011 (KS)
FEIN: 45-3617189
NAIC: 14404
WellCare of South Carolina, Inc.
Incorporated 11/8/2002 (SC)
FEIN: 32-0062883
NAIC: 11775
Missouri Care, Incorporated
Incorporated 7/27/2006 (MO)
FEIN: 20-5862801
NAIC: 12913
Harmony Health Systems, Inc.
Incorporated 8/9/1995 (NJ)
FEIN: 22-3391045
Harmony Health Management, Inc.
Incorporated 9/7/2001 (NJ)
FEIN: 36-4467676
Harmony Health Plan of Illinois, Inc.
Incorporated 8/18/1995 (IL)
FEIN: 36-4050495
NAIC: 11229
WellCare Prescription Insurance, Inc.
Incorporated 3/24/2005 (FL)
FEIN: 20-2383134
NAIC: 10155
Comprehensive Reinsurance, Ltd.
Incorporated 12/17/2004
Cayman Islands
FEIN: 98-0448921
WellCare Health Plans of California, Inc.
Incorporated 12/15/2010 (CA)
FEIN: 27-4293249
WellCare Health Plans of Tennessee, Inc.
Incorporated 4/25/2012 (TN)
FEIN: 45-5154364
'Ohana Health Plan, Inc.
Incorporated 5/21/2009 (HI)
FEIN: 27-0386122
Harmony Behavioral Health, Inc.
Incorporated 8/10/2005 (FL)
FEIN: 20-3320236
Harmony Behavioral Health IPA, Inc.
Incorporated 7/29/2005 (NY)
FEIN: 20-3262322
WellCare Pharmacy Benefits Management, Inc.
Incorporated 5/10/2006 (DE)
FEIN: 20-4869374
Exactus Pharmacy Solutions, Inc.
f/k/a WellCare Specialty Pharmacy, Inc.
Incorporated 1/24/2007 (DE)
FEIN: 20-8420512
Comprehensive Health Management, Inc.
Incorporated 12/22/1998 (FL)
FEIN: 59-3547516
WellCare Health Insurance of New York, Inc.
Incorporated 4/6/1993 (NY)
FEIN: 11-3197523
NAIC: 10884
WellCare Health Insurance of Arizona, Inc.
Incorporated 11/15/1972 (AZ)
FEIN: 86-0269558
NAIC: 83445
WellCare Health Insurance Company of Kentucky, Inc.
f/k/a WellCare Health Insurance of Illinois, Inc.
Incorporated 3/27/1962 (KY)
FEIN: 36-6069295
NAIC: 64467
Windsor Health Group, Inc.
Incorporated 9/18/2000 (TN)
FEIN: 62-1832645
Windsor Management Services, Inc.
Incorporated 5/4/1993 (TN)
FEIN: 62-1530448
Windsor Health Plan, Inc.
Incorporated 5/14/1993 (TN)
FEIN: 62-1531881
NAIC: 95792
WellCare of Nebraska, Inc.
Incorporated 10/20/2015 (NE)
FEIN: 47-5458872
Legend
ENTITY_TYPE
Non-Licensed Entity
Licensed
Limited Liability Company
Not-for-Profit Corporation

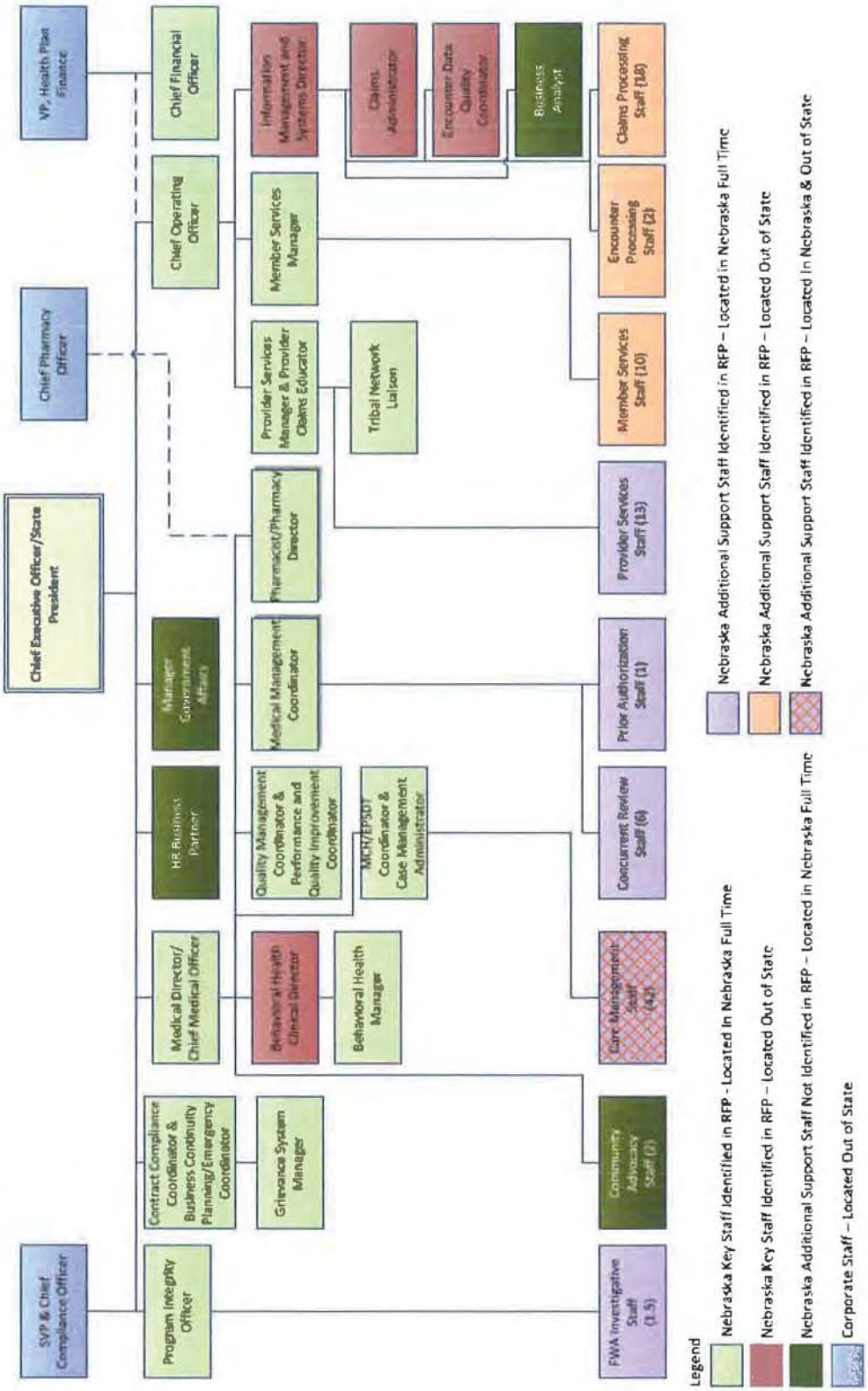
IV.D STAFFING REQUIREMENTS

16. Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart"

Heritage Health members will have dedicated, experienced staff working throughout the state of Nebraska to help them achieve their best health. As the organizational chart on the following page (**Figure 3**) indicates, WellCare of Nebraska will have key, additionally required and supplemental staff sufficient to fulfill all contract requirements and deliver best in class care to its members.

Figure 3

Nebraska Organizational Chart



IV.D STAFFING REQUIREMENTS

17. 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."

Proposed FTEs by Discrete Time Period for each key staff and additional staff. **(Figure 4)**

Figure 4

	Proposed FTEs by Time Period						
	Position Location	Mar-Apr- May 2016	Jun-Jul-Aug 2016	Sept-Oct-Nov 2016	Dec- Jan-Feb 2016-2017	Mar-Apr-May 2017	Jun-Jul-Aug 2017
Chief Executive Officer	Nebraska	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Medical Director/Chief Medical Officer			1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Behavioral Health Clinical Director	Florida	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Behavioral Health Manager	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Chief Operating Officer	Nebraska	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Chief Financial Officer	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Program Integrity Officer	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Grievance Systems Manager	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Business Continuity Planning and Emergency Coordinator	Nebraska	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Contract Compliance Coordinator	Nebraska	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Quality Management Coordinator	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Performance and Quality Improvement Coordinator	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Medical Management Coordinator	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Provider Services Manager	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Member Services Manager	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Claims Administrator	Florida	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Provider Claims Educator	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Case Management Administrator	Nebraska		0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
Information Management and Systems Director	Florida	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE

Proposed FTEs by Time Period							
	Position Location	Mar-Apr- May 2016	Jun-Jul-Aug 2016	Sept-Oct-Nov 2016	Dec- Jan-Feb 2016-2017	Mar-Apr-May 2017	Jun-Jul-Aug 2017
Encounter Data Quality Coordinator	Florida	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Tribal Network Liaison	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Pharmacist/Pharmacy Director	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Additional Staff Positions Identified in RFP							
FWA Investigative Staff							
SIU Investigator	Nebraska			1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE
Concurrent Review Staff							
Inpatient Care Nurse	Nebraska			6 FTE	6 FTE	6 FTE	6 FTE
Prior Authorization Staff							
Outpatient Care Nurse	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Care Management Staff							
Field Care Coordinator, Registered Nurse	Nebraska			2 FTE	10 FTE	10 FTE	10 FTE
Clinical Social Worker	Nebraska				3 FTE	3 FTE	3 FTE
Supervisor, Field Service Coordination	Nebraska			2 FTE	2 FTE	2 FTE	2 FTE
Manager Field Service Coordination	Nebraska			2 FTE	2 FTE	2 FTE	2 FTE
Clinical HEDIS Practice Advisor	Nebraska				4 FTE	4 FTE	4 FTE
Care Gap Coordinator	Nebraska				1 FTE	1 FTE	1 FTE
Field QI Project Manager	Nebraska				1 FTE	2 FTE	2 FTE
Quality Analyst	Nebraska				1 FTE	1 FTE	1 FTE
Disease Manager	Florida				8 FTE	8 FTE	8 FTE
Health Services and Wellness Coach	Florida				1 FTE	1 FTE	1 FTE
Supervisor, Disease Management	Florida			1 FTE	1 FTE	1 FTE	1 FTE

PROPOSED FTEs BY TIME PERIOD							
	Position Location	Mar-Apr- May 2016	Jun-Jul-Aug 2016	Sept-Oct-Nov 2016	Dec- Jan-Feb 2016-2017	Mar-Apr-May 2017	Jun-Jul-Aug 2017
Health Services Communication & Quality Auditor	Florida				1 FTE	1 FTE	1 FTE
Inpatient Care Nurse	Florida				6 FTE	6 FTE	6 FTE
Behavioral Health Care Manager	Florida				2 FTE	2 FTE	2 FTE
Provider Services Staff							
Senior Manager, Network Development	Nebraska	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Network Development Representative	Nebraska	2 FTE	4 FTE	4 FTE	4 FTE	4 FTE	4 FTE
Network Development Specialist	Nebraska	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE
Provider Relations Representative	Nebraska			2 FTE	4 FTE	4 FTE	4 FTE
Provider Operations Coordinator	Nebraska		3 FTE	3 FTE	3 FTE	3 FTE	3 FTE
Member Services Staff							
Customer Service Representative	Florida			5 FTE	10 FTE	10 FTE	10 FTE
Encounter Processing Staff							
Operations Data Analyst	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Encounter Processing Specialist	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Claims Processing Staff							
Claims Processor	Florida				4 FTE	4 FTE	4 FTE
Claims Coding Specialist	Florida				3 FTE	3 FTE	3 FTE
Supervisor, Configuration	Florida				1 FTE	1 FTE	1 FTE
Business Analyst	Florida				2 FTE	2 FTE	2 FTE
Configuration Specialist	Florida				4 FTE	4 FTE	4 FTE
Recovery Analyst	Florida				1 FTE	1 FTE	1 FTE
Operations Support Specialist	Florida				1 FTE	1 FTE	1 FTE

Proposed FTEs by Time Period							
	Position Location	Mar-Apr- May 2016	Jun-Jul-Aug 2016	Sept-Oct-Nov 2016	Dec- Jan-Feb 2016-2017	Mar-Apr-May 2017	Jun-Jul-Aug 2017
Additional Staff (Not Required in RFP)							
Community Advocacy Staff							
Community Advocate	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Senior Community Advocate	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Pharmacy Staff							
Pharmacy Technician	Florida			6 FTE	6 FTE	6 FTE	6 FTE
Technician, Clinical Services	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Regional Pharmacy Director	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Information Technology Staff							
Regional Systems Support Specialist	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Business Analyst	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Systems Support Specialist	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Application Administrator	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Software Engineer	Florida			5 FTE	5 FTE	5 FTE	5 FTE
Operations Staff							
Operations Account Representative	Florida			4 FTE	4 FTE	4 FTE	4 FTE
Operations Data Analyst	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Telecom Analyst	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Credentialing Specialist	Florida			2 FTE	2 FTE	2 FTE	2 FTE
Enrollment Specialist	Florida			1 FTE	1 FTE	1 FTE	1 FTE
Project Manager	Florida			2 FTE	2 FTE	2 FTE	2 FTE
Finance Staff							
Accounting Clerk	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Senior Director, Actuary	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Actuarial Associate	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Financial Analyst, Senior	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE

PROPOSED FTEs BY TIME PERIOD							
	Position Location	Mar-Apr- May 2016	Jun-Jul-Aug 2016	Sept-Oct-Nov 2016	Dec- Jan-Feb 2016-2017	Mar-Apr-May 2017	Jun-Jul-Aug 2017
Financial Analyst	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Statutory/Cost Accountant	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Market Support Staff							
Human Resources Business Partner	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Manager, Government Affairs	Nebraska		1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
Executive Assistant	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE
Administrative Assistant	Nebraska			1 FTE	1 FTE	1 FTE	1 FTE

IV.D STAFFING REQUIREMENTS

18. Provide job descriptions (including education and experience qualifications) of employees in key staff positions. *(Page limit 1 page per job description)*

WellCare is committed to hiring and retaining a highly productive, customer-oriented, engaged workforce. Our systemic recruitment process is highly selective and ensures that experienced, well-trained personnel will be provided to support implementation and ongoing administration of Nebraska's Heritage Health program.

Please see the following one page documents for the job descriptions which correspond with key staff positions.

Chief Executive Officer

GENERAL JOB INFORMATION

Title: Chief Executive Officer

JOB SUMMARY

Responsible for the overall operations of the health plan, including strategic direction, administration of all existing programs and development of new programs to ensure goals and objectives are met or exceeded. Working closely with the Division President and WellCare's executive leadership team, leads and directs overall operations including: provider contracting and relations, sales and marketing, medical management, regulatory compliance, government relations and finance, as well as interfacing with corporate office operations. May serve as the representative of the health plan to government entities and other external agencies. Ensures compliance with all relevant state and federal regulatory agencies, contracts and regulations. Incumbent will be responsible for supporting the State contract on a full-time basis.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Providing overall direction and prioritization for the local state plan.
- Develop and carry out all leadership strategies and initiatives associated with supporting the state contract.
- Ensure that the policies and contractual requirements are followed.
- Leads and directs the day to day operations of the health plan. This includes providing leadership and direction to the management team to ensure the organization's strategic plan is translated into tactical goals and objectives that guarantee performance objectives are met or exceeded.
- Developing and implementing integration models that ensure coordination with state customers and other system partners.
- Sets the tone from the top that compliance with all regulations and contract adherence is critical to WellCare success.
- Directs and manages the organization's financial performance. Takes appropriate actions to increase revenue, leverage resources, manage and/or minimize expenses.
- Directs the development of annual budgets and presents the budgets for approval.
- Establishes formal and informal mechanisms to promote and maintain credibility, competence, and a positive corporate image by exhibiting strong communication to the corporate office, providers, members and committees.
- Leads organizational development activities that develop and foster strong working relationships among the members of the management team. Builds and promotes the culture to be consistent with the values established by the corporate office.
- Assists and leads where appropriate, with aspects of state and federal government relationships, including working with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met.
- Recommends and leads improvement processes and initiatives

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	business administration, finance, healthcare administration or a related field	Required
A Master's Degree in a related field		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
5+ years of experience in	senior management with profit and loss accountability for a managed care organization	Required

Medical Director

GENERAL JOB INFORMATION

Title: Medical Director

JOB SUMMARY

Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations. Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease Management activities, quality improvement activities, and provider relations functions. Incumbent will be dedicated full time to the local contract.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Developing, implementing, and interpreting medical policies and procedures. Duties may include, but are not limited to: service authorizations, claims review, discharge planning, credentialing, referral management, and medical review of grievances and appeals.
- Administrating the medical management activities of the local plan.
- Participating via telephone or in person at every Quality meeting with the state customer and other system partners, and as requested by the state customer.
- Leading the Utilization Management, Quality Assessment and Performance Improvement, Credentialing, and Provider Advisory committees.
- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services.
- Provides current medical expertise and direction for clinical policies, procedures and programs.
- As required by business and operational priorities, establishes professional working relationships with providers and provider organizations to support the development of the highest possible provider partnerships.
- Works closely with other medical directors and clinical services staff to attain and/or maintain compliance with company, customer, accreditation and regulatory requirements.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Doctor in Medicine (MD)	or D.O. from an accredited school of medicine recognized by national medical regulatory bodies in the United States	Required

Work Experience

Experience Level	Experience Details	Required/Preferred
5+ years of experience in	Direct patient care providing clinical services	Required
3+ years of experience in	Medical specialty training	Required
Other	Substantial experience and expertise in the development of medical policies, procedures and programs	Required
Other	Demonstrated success implementing utilization and quality improvement strategies /techniques and experience with physician behavior modification	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Doctor of Medicine (MD)		Required
Other	An unrestricted and current license to practice medicine in the state of employment (or the ability to obtain one)	Required
Other	Board Certification	Required

Behavioral Health Clinical Director

GENERAL JOB INFORMATION

Title: Behavioral Health Clinical Director

JOB SUMMARY

Serves as the lead clinical strategist and spokesperson for WellCare Integrated Medical Behavioral Health Solutions. Provides guidance and consultation to behavioral health which may include Health Concurrent Review, Case Management, and Provider Relations. Oversees all clinical aspects of Behavioral Health, and helps establish policy and procedures for Behavioral Health, including its integration with medical care and pharmacy. Serves as a key representative and spokesperson with respect to the external behavioral health community in the market. Supports Behavioral Health Operations improvement of the network delivery system in the market, including working collaboratively with providers to encourage development of new and more community based types of care and better integrating behavioral health with physical health and social services.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Incumbent will be responsible for providing clinical case management consultations and clinical guidance for contracted PCPs treating behavioral health-related concerns not requiring referral to behavioral health specialists.
- Responsible for developing comprehensive care management programs for youth and adults with behavioral health concerns, typically treated by PCPs, such as ADHD and depression.
- Developing targeted education and training for the local plan's PCPs that commonly encounter behavioral health issues.
- Provides overall clinical thought leadership in behavioral health for WellCare. This person will be responsible for overseeing all clinical aspects of behavioral health, including care and utilization management, network and provider relations, quality improvement, health IT, and overall administration including legal and finance.
- Responsible for overseeing and ensuring integration of behavioral health health into all functional areas of the health plan, and working collaboratively with corporate behavioral health and medical staff to implement integrated policies and procedures. Provides reliable assistance to the assigned market medical director and clinical staff to assure effective integration of behavioral services into health plan medical management activities.
- Helps establish policy and procedures for behavioral health, including its integration with medical care and pharmacy. This person will be the thought leader for behavioral health, and will provide teaching, training, coaching, and supervision of internal staff.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Doctor in Medicine (MD)	Or D.O. from an accredited school of medicine recognized by national medical regulatory bodies	Required

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Behavioral Health Services, such as prior authorization, intake, concurrent review, case management, discharge planning including development and management	Required
5+ years of experience in	Clinical practice – a minimum of 5 years of combined clinical experience in mental health and substance use disorder services.	Required
Other	Managed behavioral healthcare industry, Medicare and Medicaid experience including knowledge about primary care/behavioral health integration.	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Doctor of Medicine (MD)	Board certified and unrestricted and current state license	Required
Licensed Psychiatrist	Currently practicing psychiatrist or psychologist with an unrestricted license in each state served	Required

WellCare

Behavioral Health Manager

GENERAL JOB INFORMATION

Title: Behavioral Health Manager

JOB SUMMARY

Manages overall behavioral health services in a dedicated WellCare market/state. Interacts extensively with the behavioral health leadership and cross functional associates within the market to develop and implement behavioral health program strategies. Directs and facilitates behavioral health clinical training programs for associates, and external behavioral/medical provider community. Assists with behavioral health program and services development of policy and procedure, clinical criteria, workflows and other behavioral health documentation. Serves as behavioral health subject matter expert and supports the needs of the WellCare market leadership. Serves as behavioral health management liaison between the market and the corporate office clinical teams.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Ensuring that the local plan's behavioral health operations, providers, and any subcontractors are in compliance with all regulatory and contractual requirements.
- Coordinating all areas of the MCO, including quality management, utilization management, network development and management, provider services, member outreach and education, member services, contract compliance, and reporting for behavioral health.
- Oversees the day-to-day operations for the Behavioral Health services which includes activities for a state specific market designed to achieve quality and service driven objectives.
- Assists with development of clinically-focused training associated with behavioral health assessment, care plan development and behavioral health services in the market(s) or state.
- Establish, maintain and foster professional working relationships with all behavioral health providers and develops regular and ongoing working relationship with the community mental health system in the market including community mental health centers, treatment facilities and other significant behavioral health providers in the market.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Master's Degree in	Social Work, Psychology, Counseling, Rehabilitation, or other relevant field that provides a foundation to receive a license as required of the position	Required

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	Behavioral health management and/or acute behavioral health care setting focusing on outpatient/inpatient utilization, case management and discharge planning	Required
3+ years of management experience		Required
4+ years of experience in	A managed care environment (as a licensed mental health professional)	Required
Other	Experience working with the needs of vulnerable populations who have chronic or complex bio-psychosocial needs	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Other	One of the following is required in the state the individual will serve: Licensed Clinical Marriage & Family Therapist (LCMFT); Licensed Clinical Mental Health Counselor (LCMHC); Licensed Clinical Psychologist (LCP); Licensed Clinical Psychologist (LCP); Licensed Clinical Social Worker (LCSW); Licensed Clinical Professional Counselor (LCPC)	Required

Chief Operating Officer

GENERAL JOB INFORMATION

Title: Chief Operating Officer

JOB SUMMARY

Executes strategies to meet or exceed annual goals and objectives in the area of Customer Service, Enrollment, Retention, Claims, site operations and staff oversight in a the state. Provides support to the State Chief Executive Officer with project and initiative leadership, as well as organizational development. Facilitates problem identification, solution development, and initiative implementation on behalf of the State Chief Executive Officer and Leadership Team. Provides executive oversight for Enrollment and Retention within Customer Service, and directs activities for Customer Service. Position is also responsible for directing the claims department's processing activities in support of established production and quality standards. Leads and manages all hands-on operational aspects and activities of various functional areas within the Plan which may include: Claims, Provider Services, Information Technology, Grievance and Appeals and Member Services. Assists the Plan leader in the successful growth and performance of the Plan.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Managing the day-to-day operations of the state plan's departments, staff, and functions to ensure that performance measures and state customer and Federal requirements are met.
- Incumbent will serve as the primary contact with the state customer concerning all operational issues.
- Accountable for the management and execution of special projects as assigned by the Plan President that may interface across multiple functional areas, and liaise with external constituents as needed to build relationships or deliver results.
- Directs long and short term planning for the departments including manpower, facilities, training, and system requirements. Develops an directs the implementation of strategies to substantially improve efficiencies, deliver process improvement and invoke quality service while reducing costs.
- Directs and oversees claims processing activities with the objective of meeting production, timeliness, quality standards, and to ensure that services comply with governmental and accrediting agency regulations. Participates with other health plan departments in planning, coordinating, and problem solving in regard to claims operations and customer service.
- Establishes business or function goals, performance standards, operational priorities and manages allocation utilization of resources to achieve operational goals and budgets.
- Plans, provides resources, and directs activities for the business of the function (or multiple functions) within Configuration, in which assignments are broad in nature, usually requiring considerable creativity, originality and ingenuity.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field		Required
A Master's Degree in a related field		Preferred

Work Experience

State the minimum required for the job

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	An operations environment specifically with claims, customer service, provider services administration, project management and/or information technology	Required
5+ years of management experience		Required
Other	Experience with the design, development and administration of managed health care programs (Medicaid and other Government programs). Demonstrate successful experience in cross functional team implementation, projects, etc.	Required
Other	Excellent human relations, leadership and interpersonal relationship skills, engagement of employees, staff coaching skills required	Required

WellCare

Chief Financial Officer

GENERAL JOB INFORMATION

Title: Chief Financial Officer

JOB SUMMARY

Position plans, provides resources and directs activities for state plan financial-related activities and analysis. Provides analytics for strategic and operating decisions. Leads all state plan audit activities, accounting systems, financial reporting, and budgeting.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Leads the contract modeling process
- Manages the financial analysis of medical cost
- Manages state plan capitation calculation and payment
- Administers risk contracts
- Provides ad-hoc analysis for senior management
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources
- Ensures corporate initiatives are implemented to achieve optimum results

Additional Position Responsibilities – Optional

- Advises management in long-range planning for areas of specialization
- Provides technical direction to functional managers, other directors and management
  Recommends changes in area(s) policy and procedure

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field		Required
A Master's Degree in a related field		Required

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of management experience	Healthcare financial management	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Certified Public Accountant (CPA)		Preferred

Program Integrity Officer

GENERAL JOB INFORMATION

Title: Program Integrity Officer

JOB SUMMARY

Implements policies, procedures, and practices designed to ensure compliance with the requirements set forth in the Corporate Integrity Agreement (CIA), applicable federal and state Plan contracts, laws, regulations, health care program requirements, and fraud, waste, and abuse monitoring and prevention. Serves as the contact for the Chief Compliance Officer for compliance and ethics activities in the Market. Functions as the local contact for the Corporate Compliance Department's functional units and serve as a Market resource for identifying, tracking, mitigating and reporting on operational compliance risks. The program integrity officer reports director to the State Chief Executive Officer.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program.
- Developing/overseeing methods to prevent and detect potential FWA and erroneous payments.
- Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans.
- Reviewing records and referring suspected member FWA to the state customer and other duly authorized enforcement agencies.
- Managing the state plan's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit.
- Establish and lead the Market Compliance Committee. Ensure meeting minutes are collected and archived.
- Complete Market Compliance Assessment – Quarterly Performance Report Work plan and compile Quarterly Performance Report for submission to Market leader and Chief Compliance Officer.
- Partner with WellCare's Internal Audit Department on Market-based assessments
- Guide the escalation path within the market for compliance related and ethical issues and involve the appropriate resources and support from Corporate Compliance as needed.
- Conduct and track on-site compliance trainings and provide updates to the field organization.
- Serve as Market subject matter expert for HIPAA, assess compliance with HIPAA requirements, perform periodic HIPAA audits of office location(s) and guide remediation plans.
- Serve as Market Local Record Coordinator for the Records Information Management department. Perform training and oversight as needed.
- Serve as the local compliance and oversight contact for Compliance applications (LIONS, C360).
- Collaborate with Regulatory Affairs to remain current on state regulatory register, comply with reporting requirements and serve as an integrated compliance voice during the planning and execution phases of Market programs and projects.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field or equivalent work experience	5 years of relevant work experience	Required
A Master's Degree in	Business Administration, Public Health, or Healthcare Administration	Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
5+ years of experience in	Business setting	Required
Other	Experience in health care and/or risk management	Required
Other	Experience in Corporate compliance, regulatory affairs or state government preferred	Preferred
Other	Managed care experience preferred	Preferred

Grievance System Manager

GENERAL JOB INFORMATION

Title: Grievance System Manager

JOB SUMMARY

Directs the organization with the critical information needed to make fact-based decisions, including building a strong business alignment with internal and external customers and providing key internal and external customers with information and analytics. Manages business and reporting analysts to produce operational reports by state and by product to management and external audit teams on time; continuously identify process to automate/eliminate reports by applying business process improvement and process reengineering to the report development wherever possible. Leads the local plan in managing and adjudication member grievances, appeals, and requests for fair hearings. Leads the local plan in managing and adjudicating provider grievances and appeals. Leads staff in gathering business requirements, preparing logical and physical reporting environments, and completing design, coding, testing and implementation of business intelligence reports. Works closely with other Analytics teams and program groups in providing effective reporting solutions

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Manages the complete end-to-end process of receiving, processing, and adjudicating member and provider grievances and appeals in accordance with state and Federal regulations.
- Ensures that member requests for state fair hearings are executed according to state and Federal regulations.
- Provides senior leadership team with adequate information to make decisions (both strategic & tactical).
- Analyzes reports, creates trend lines and makes recommendations/explanations.
- Designs and builds utilization management dashboards/reports/models.
- Performs in depth analysis of current trends to enable organization to diagnose and respond to changing competitive landscape.
- Proactively evaluates macro-market data, technology and benchmarks to discern trends, anomalies, and areas of opportunities. Works with internal report production teams to evaluate historical performance and forecast future performance.
- Interprets, creates final recommendations and presents the results to key stakeholders.
- Develops and directs the implementation of strategies to substantially improve data processing efficiencies.
- Leads the execution of projects based on predictive analytics, customer segmentation and modeling, ad hoc business analytics and customer behavior reporting in support of internal global business partners.
- Designs, develops and implements analytical models using appropriate data mining and statistical tools, analyze results and work cross-functionally to generate actionable recommendations.
- Identifies and manages outside vendor relationships, where appropriate.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field		Required
A Master's Degree in a related field		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	An analytical role supporting business departments.	Required
5+ years of experience in	Marketing/customer database analytics such as: analytic segmentation, measurement of strategy development, ROI analysis, modeling, web analysis, etc.	Required
3+ years of experience in	Managing and adjudicating member and provider grievance and appeals in a Medicaid managed care environment.	Required

Business Continuity Planning and Emergency Coordinator

GENERAL JOB INFORMATION

Title: Business Continuity Planning and Emergency Coordinator

JOB SUMMARY

Leads the state plan's business continuity and emergency preparedness procedures. Works with the State Regulatory Affairs department to ensure continuity of care and services for members who may experience evacuation to other areas of the State or our-of-state, during disasters. Responsible for developing the policies and procedures and executing the strategy focused on the state plan's emergency management plan. Provides guidance, oversight and support to the organization with respect to business continuity and emergency management.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Ensures continuity of benefits and services for members who may experience disruption or displacement due to evacuation during natural disasters.
- Manages, oversees, and executes on the state plan's emergency management plan.
- Identifies compiles and aggregates regulatory and operational issues across markets to manage risk. Partners with markets on resolutions through expertise and lessons learned.
- Makes timely and effective decisions using data and takes a fact-based approach to problem-solving, while understanding the limits of data to make and support decisions.
- Manages and supports audits and various systems testing to ensure the state plan is prepared to effectively deliver continuity of benefits and services in advance of potential disruptions and/or displacement.

MINIMUM QUALIFICATIONS

Education

State the minimum required for the job

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	Business administration or related field	Required
A Master's Degree in	Public policy, public health, political science, health administration or related field	Preferred

Work Experience

State the minimum required for the job

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Managed health care or health care consulting	Required
5+ years of experience in	Business continuity procedures, emergency preparedness responsibility, or audit and system testing protocols	Required

Contract Compliance Coordinator

GENERAL JOB INFORMATION

Title: Contract Compliance Coordinator

JOB SUMMARY

Leads the state regulatory affairs function, with responsibility for developing and executing the Medicaid Regulatory Affairs strategy focused on publicly funded healthcare programs. Responsible for developing and executing strategies to adhere to all contract compliant operations in a specified state or region. Provides guidance, oversight and support to regulatory affairs teams with respect to contract administration and account management.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Coordinates the preparation and execution of contract requirements.
- Coordinating the tracking and submission of all contract deliverables.
- Responding to inquiries from the state customer on behalf of the state plan.
- Coordinating and performing random and periodic audits and ad hoc visits.
- Identifies, compiles and aggregates regulatory and operational issues to manage risk. Works with leadership to develop appropriate course of action and resolution.
- Makes timely and effective decisions using data and takes a fact-based approach to problem-solving, while understanding the limits of data to make and support decisions.
- Ensures the achievement of established business results in both the regulatory affairs and product ownership components as defined by the Chief Executive Officer.
- Establishes the Medicaid regulatory affairs strategies and oversees contract administration activities in markets.
- Manages and supports audits, and ensures the appropriate and satisfactory implementations of regulatory requirements.
- In partnership with Corporate Compliance, develops procedures and toolkits, and reports and monitors contractually required deliverables, including but not limited to, regulatory reports and performance metrics.
- Directs and manages a team of associates responsible for supporting Medicaid regulatory affairs initiatives and teams.
- Supports the development and implementation of regulatory affairs best practice in new markets.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	Business administration or related field	Required
A Master's Degree in	Public policy, public health, political science, health administration or related field	Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Managed health care or health care consulting	Required
7+ years of experience in	Regulatory affairs, government relations, compliance or related disipline	Required
5+ years of management experience		Required

Quality Management Coordinator

GENERAL JOB INFORMATION

Title: Quality Management Coordinator

JOB SUMMARY

Plans, develops and directs the Quality Management functions. Provides leadership necessary to achieve national best practice performance levels in quality improvement while implementing evidence based medicine/practices. Ensures that the quality of healthcare services rendered meets or exceeds professionally recognized community standards. Interfaces with a diverse range of clinical and administrative professionals, resolves sometimes-complex policy and service issues within the group and directs data analytic and reporting activities that are prescribed by customers and regulators in a complex environment. Ensures compliance with state, federal and accreditation requirements. Dedicated full time to the local state plan.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Identifies and implementing process improvements.
- Integrates quality throughout the organization.
- Ensures a network of credentialed providers.
- Develops and implements quality improvement plan in accordance with the mission and strategic goals of the organization, federal and state laws and regulations, and accreditation standards. Ensures systemic and individual quality of care.
- Establishes professional relationships with state, stakeholders and community agencies to facilitate quality process internally and externally.
- Develops and implements systems, policies, and procedures for the identification, collection, and analysis of performance measurement data. Resolved, tracking, and trending quality of care grievances.
- Analyzes, updates, and modifies standard operating procedures and processes to continually improve QI Department services/operations including but not limited to quality of care complaint/adverse event investigations, and ambulatory medical record review assessments.
- Assists in strategizing and facilitating various committee structures and functions to best address the QI process and oversees Quality Committees. Serves as a member of the Quality Assurance Performance Improvement Committee and member/ad hoc member of other quality related committees.
- Oversight and interface internally and externally with pay for performance programs and initiatives

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	HealthCare, Nursing, Public Health, Health Administration or directly related field	Required
or equivalent work experience		
A Master's Degree in a related field		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	Directly related Quality Improvement job functions	Required
5+ years of experience in	Managed care	Required
4+ years of management experience		Required
Other	Excellent knowledge of JCAHO, URAC, AAAHC and NCQA standards	Required

Licenses and Certifications

Licenses/Certifications	Required/Preferred
State License as a Registered Nurse (RN), physician, or physician's assistant	Required
Certified Professional in Healthcare 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.	Required

Performance and Quality Improvement Coordinator

GENERAL JOB INFORMATION

Title: Performance and Quality Improvement Coordinator

JOB SUMMARY

Oversees the production, comprehensiveness, and accuracy of all data used in and related to the Company's health care quality operations, including HEDIS reporting, State Medicaid quality reports, Medicare quality reports, data to support performance improvement projects, and other ad hoc reports as required, both regulatory-required and internal. Focuses the organizational efforts on the improvement of clinical quality performance measures. Ensures that data sources are of the highest quality by working with staff members from other departments such as Information Technology, National Contracting, and local market Network Leadership. Serves and / or leads committees and workgroups tasked with data quality improvement. Works with all stakeholders at headquarters and in each market to formulate and implement action plans for data quality improvement.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Ensures production of complete and accurate HEDIS and other Quality data. Utilizes data to develop intervention strategies to improve outcomes.
- Interfaces cross-functionally with IT, Encounters Team, National Ancillary, and Market Network leadership to ensure all key quality data sources are being captured.
- Leads development and implementation of performance improvement projects, both internal and across external stakeholders.
- Manages non-clinical aspects of HEDIS Reporting and Medical Record Review process.
- Oversees the on-time submission of all required State and Federal quality and other medical informatics reports due to regulators. Maintains and updated database with specification and due dates of such reports, including a process for understanding and incorporating new / revised reporting requirements. Works to migrate jobs to production reporting (where appropriate) and optimize coding efficiency.
- Consults with and serves as a resource with other departments, both within Health Services and throughout the organization, such as IT, marketing, product development, compliance and regulatory, and others as needed, for the purpose of insuring coordination in systems planning, development, and implementation between the claims management system, the Quality reporting system, the Enterprise Medical Management Application (EMMA), and other internal applications and databases.
- Conducts assessments of the medical informatics environment using data quality and stakeholder satisfaction metrics to synthesize pertinent information and identify implications for planning and development of both information services and data improvement programs. These reviews will be summarized at regular intervals to provide a structured environmental assessment and recommendations relative to future direction for medical informatics for Health Services.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	Finance, Statistics, Math or relevant field	Required

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Medical informatics with advanced training in medical informatics	Required
5+ years of management experience		Required
Other	Managed care experience	Preferred
Other	Extensive prior experience with HEDIS reporting	Required

Licenses and Certifications

Licenses/Certifications	Required/Preferred
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.	Required
Licensed Registered Nurse (RN)	Preferred

Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator

GENERAL JOB INFORMATION

Title: Maternal Child Health (MCH)/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator

JOB SUMMARY

Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the member. Designs programs to ensure that all members who are children receive necessary EPSDT services and to ensure that all pregnant members receive maternal and postpartum care. Oversees the socio economic needs and services of selected member populations across the continuum of illness. Takes part in extensive community outreach to garner relationships with key stakeholder groups and organizations.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Manages and develops direct reports who conduct both case management and social service functions within a member's care plan.
- Promotes appropriate health care initiatives including family planning and preventative care health strategies.
- Proactively monitors appropriate metrics to drive up efficiency.
- Directs the case management process, providing advice when necessary of complex, and identifying and coordinating assistance for identified member needs, specific to maternal/child health and EPSDT.
- Establish, maintain and foster professional working relationships with all providers and community stakeholders.
- Partners & collaborates with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Manages & resolves e-mails and escalated phone issues in response to provider, staff and other department requests.
- Directs work assignments, measures results and initiates personnel actions as required.
- Participates in continuous quality improvement projects that involve case and social service components.
- Ensure timely and complete delivery of required regulatory reports.
- Serve on community advisory boards and task forces to address workforce and other long-term care challenges.
- Ensures compliance with all state and federal regulations and guidelines for all lines of business.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Master's Degree in	Health Services, public health, or health care administration	Required

Work Experience

State the minimum required for the job

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Current case management	Required
5+ years of management experience		Required
5+ years of experience in	Managed care	Required

Licenses and Certifications

List professional licenses and certifications associated with this job

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
State Licensed Registered Nurse (RN), Physician, or Physician's Assistant		Required
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.		Preferred
Certified Case Manager (CCM)		Preferred

Medical Management Coordinator

GENERAL JOB INFORMATION

Title: Medical Management Coordinator

JOB SUMMARY

Accountable for providing vision and strategy for inpatient and outpatient utilization and prior authorization management activities designed to achieve quality and service-driven objectives. Oversees all phases of development, organization, planning and implementation of projects/initiatives/workflows/processes to enhance quality-driven outcomes. Develops, implements and monitors the provisions of care coordination, disease management, and case management functions.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Provides direction and oversight to ensure effective management of inpatient care, discharge planning, and prior authorizations.
- Optimizes processes and workflows to achieve successful quality outcomes and benefit maximization within the scope of responsibility.
- Monitors, analyzes, and implements appropriate intervention based on utilization data, including the identification and correction of over- or under-utilization of services.
- Serves as an instrumental partner in development of key performance indicators. Monitors and tracks key performance indicators to independently identify over/under utilization patterns and/or deviation from expected results.
- Ensures the completion of appropriate concurrent review and discharge planning of inpatient stays.
- Executes periodic competitor utilization management program comparison and analysis to ensure WellCare's utilization management program maintains competitive edge.
- Develops processes and procedures to ensure department-wide compliance with contractual, regulatory (Federal/State) and accreditation entities.

  Monitors prior authorization function and ensures that decisions are made in a consistent manner, based on clinical criteria, and that all decision meet timeliness standards.
- Leads talent management activities to develop and cultivate future leaders.
- Promotes and improves environment of Provider and Health Plan partnership.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	Nursing (BSN), Health Administration, Nutrition or business related field	Required
A Master's Degree in	Business, Public Health or Healthcare administration	Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	Acute clinical/surgical experience and/or behavioral health clinical setting	Required
3+ years of management experience	In a managed health care setting	Required
Other	Current experience in utilization management to include pre-authorization, utilization review, concurrent review, discharge planning, and/or skilled nursing facility reviews	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
State Licensed Registered Nurse (RN), Physician, or Physician's Assistant		Required
Other	Utilization review/management certification, or equivalent professional certification	Preferred

Provider Services Manager

GENERAL JOB INFORMATION

Title: Provider Services Manager

JOB SUMMARY

Strategizes for optimal business practices and efficiencies with an emphasis on delivering exceptional service to contracted providers. Position plans, provides resources and directs activities in network development, provider contracting/negotiation and provider service functions.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Manages the Provider Services Staff. Sets goals for their area and works closely with Managers/Representatives to drive performance and to ensure provider satisfaction metrics are met or exceeded.
- Conducts field rides with Provider Relations Representatives to gauge their performance and provide coaching and development in order to improve the business results.
- Works collaboratively with the Provider Advisory Committee to establish methodologies for processing and responding to provider concerns.
- Coordinates communication between the state plan and subcontracted network providers.
- Performs data analysis and develops specific actions to manage medical cost trends.
- Develops provider trainings in response to identified needs or changes in protocols, processes and forms.
- Develops provider contracting and service strategies to enhance plan-provider communication and ensures maximum efficiencies in the utilization of human and financial resources.
- Strategizes for membership growth, retention, and to affect sophisticated or complex provider relationships.
- Serves as the primary contact in notifying the state customer of correspondence sent to providers for information and training purposes.
- Participates in the state customer's Administrative Simplification Committee.

MINIMUM QUALIFICATIONS

Education

State the minimum required for the job

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field or equivalent work experience	directly related to the level and duties of the job	Required

Work Experience

State the minimum required for the job

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	provider relations or similar background	Required

Member Services Manager

GENERAL JOB INFORMATION

Title: Member Services Manager

JOB SUMMARY

Position plans, provides resources and directs activities for the business of the function (or multiple functions) within the Member Services Call Center. Assignments are broad in nature, usually requiring considerable creativity, originality and ingenuity. The position will serve as the leader of the state plan's communication between the plan and all members.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Directs long term and short term planning for the department including manpower, facility, training, and systems requirements. This includes ensuring 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.
- Develops and directs the implementation of strategies to substantially improve efficiencies and service provided while reducing costs.
- Directs the allocation of resources to ensure goals are met.
- Develops and directs the implementation of goals and performance standards for Customer Service and its associates.
- Develops hiring and performance management strategies that enhance employee retention and morale.
- Works closely with the appropriate parties to implement state of the art initial training and quality assurance programs.
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors.
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches

  Sets operational priorities and manages resources to operational goals and budgets
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources
- With approval of Senior VP or VP establishes budget and monitors for adherence
- Ensures corporate initiatives are implemented to achieve optimum results
- Advises management in long-range planning for areas of specialization
- Provides technical direction to functional managers, other directors and management
- Directs, develops and implements appropriate changes in area(s) policy and procedures under the guidance of the SVP, Operations.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field	Or equivalent work experience	Required
Other	MBA or directly related or equivalent work experience	Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Progressively responsible management	Required
Other	Strong experience in the areas of customer service and Call Center management at the leadership level, and a deep understanding of the interrelationships between Call Center, Health Services, and Claims and their impact on the success of the health plan as a whole	Required

Claims Administrator

GENERAL JOB INFORMATION

Title: Claims Administrator

JOB SUMMARY

Position is responsible for directing the claims department's processing activities in support of established production and quality standards. Incumbent will be responsible for leading the strategic direction of the Claims Department.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Develop, implement and administer a comprehensive State-specific Medicaid Managed Care claims processing system capable of paying claims in accordance with State, Federal and contractual requirements.
- Direct and oversee claims processing activities with the objective of meeting production, timeliness and quality standards.
- Recruit, select, train and retain highly qualified professionals. Provide the senior leadership necessary to maintain a motivated, productive and competent team through open communication and delegation of responsibilities and authority.
- Identifies, defines and executes on opportunities for strategic improvement, including opportunities for increased auto adjudication of claims.
- Develop and implement a cost avoidance processes.
- Direct and oversee claims activities to ensure that services comply with governmental and accrediting agency regulations including reporting requirements.
- Partners effectively with business partners across the enterprise and within Operations (Configuration, Training, IT, etc.) to execute on critical business objectives and priorities.
- Ensure the delivery of superior customer services by providing timely and accurate claims payment and responding timely to member and provider inquiries and complaints regarding claims processing including ensuring the minimization of claims recoupments.
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors.
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches.
- Defines strategic operational priorities and manages resources to operational goals and budgets.
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources.
- Establishes the budget for the Claims Department and ensures adherence across the organization in conjunction with Finance and SVP, Operations.
- Ensures corporate initiatives are implemented to achieve optimum results.
- Perform other duties as assigned.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field		Required
or equivalent work experience		Required

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of management experience	in a managed care claims processing environment	Required
Other	Extensive experience and leading edge knowledge of best practice claim processes, measurements, rewards and systems	Required
Other	Experience in the selection and implementation of systems, and taking an active risk-taking role while implementing and achieving the savings/results	Required
Other	Medicare risk and/or Medicaid risk experience	Preferred

Provider Claims Educator

GENERAL JOB INFORMATION

Title: Provider Claims Educator

JOB SUMMARY

Directs the state operations teams specifically related to Provider contracting and payment issues both internally & externally. Creates and implements appropriate processes, monitors daily performances as it pertains to production, quality, and service to ensure company goals and departmental metrics are met. Designs and implements processes to remediate identified root cause issues. Responsible for being a subject matter expert on the state customer's grievance, claims processing, and provider services systems and facilitating the exchange of information between these systems and providers.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Establishes process between regions and corporate departments to identify, diagnose, and remediate provider operational issues (some states may also remediate member issues).
- Directs a team of geographically distributed resources to improve operational performance in the market through metric based management.
- Educate in-network and out-of-network providers on claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers, and available state plan resources, such as provider manuals, websites, provider training materials, and fee schedules.
- Establishes protocol to prioritize and manage timely resolution of regional operational issues.
- Directs a team responsible for claims adjudication at a specific level. Ensures appropriate operational controls and review processes are implemented and adhered to.
- Applies analytical tools and techniques to identify root causes, prevalence and impact of issues across multiple states/business units. Develops strategies to reduce problems and improve efficiency over time.
- Tracks and trends root causes to develop systematic solution to operational challenges. Identifies trends and guides the development and implementation of strategies to improve provider satisfaction.
- Conducts provider visits with team members to evaluate their performance and provide coaching and development in order to improve the business results.
- Communicating frequently with providers to ensure the effective exchange of information and to obtain feedback regarding the extent to which providers are informed about appropriate claims submission practices.
- Recruits, selects, trains and retains highly qualified professionals. Provides the leadership necessary to maintain a motivated, productive and competent team through open communication and delegation of responsibilities and authority.
- Works with the provider services staff to compile, analyze, and disseminate information from provider calls that indicate a need for education or process improvements.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field or equivalent work experience		Required

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	Operations management, claims processing/issue resolution or provider contracting	Required
5+ years of experience in	Operational process and root cause analysis	Required
5+ years of experience in	Management and supervisory experience in a health care field	Required
Other	Significant multi-departmental project management	Required
Other	Data and work process analysis and problem identification	Required
Other	Medicare and/or Medicaid experience	Preferred

Case Management Administrator

GENERAL JOB INFORMATION

Title: Case Management Administrator

JOB SUMMARY

Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the member. Oversees the socio economic needs and services of selected member populations across the continuum of illness. Takes part in extensive community outreach to garner relationships with key stakeholder groups and organizations.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Manages and develops direct reports who conduct both case management and social service functions within a member's care plan.
- Oversees the state plan's case management functions.
- Works with key program stakeholders, including other health plans, to ensure that members' case management needs are met.
- Proactively monitors appropriate metrics to drive up efficiency.
- Directs the case management process, providing advice when necessary of complex, controversial and/or unique administrative processes, medical procedures and payment guidelines.
- Works with the Medicaid Director and other medical management staff to ensure that the state plan has case management policies and protocols that comply with Federal and State requirements.
- Partners & collaborates with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Manages & resolves e-mails and escalated phone issues in response to provider, staff and other department requests.
- Directs work assignments, measures results and initiates personnel actions as required.
- Participates in continuous quality improvement projects that involve case and social service components.
- Ensure timely and complete delivery of required regulatory reports.
- Serve on community advisory boards and task forces to address workforce and other long-term care challenges.
- Ensures compliance with all state and federal regulations and guidelines for all lines of business.
- Performs other duties as assigned.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in or equivalent work experience	Nursing, Health Administration or directly related field	Required

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Current case management	Required
5+ years of experience in	Management or supervisory experience in a health care field	Required
5+ years of experience in	Managed care	Required

Licenses and Certifications

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Licensed Registered Nurse (RN)		Required
Certified Case Manager (CCM)		Preferred

WellCare

Information Management and Systems Director

GENERAL JOB INFORMATION

Title: Information Management and Systems Director

JOB SUMMARY

Ensures the highest degree of user satisfaction by providing high-quality, high-availability information technology and services. Leads a team in the development of strategies, implementation, administration, troubleshooting, repair, monitoring and reporting of the company's IT applications and systems. Operates with a focus on continuous improvement, partnership, results and ROI. Exhibits a strong work ethic and inspires confidence as a technology steward.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Responsible for overseeing all state plan information systems functions.
- Participates in the planning, and oversees the implementation, of strategies aligned to functional area.
- Makes recommendations on matters of policy, and approves changes in functional area of expertise.
- Works collaboratively with leadership to proactively develop relationships and manage communications with key stakeholders.
- Ensures overall program management integrity through internal communication of program requirements.
- Directs work assignments, measures results and initiates personnel actions as required.
- Provides technical leadership for the design, deployment and operation of IT programs and services.
- Supports the organization to provide all necessary and timely data and reports to state customer.
- Establishes and maintains connectivity with state customer information systems.
- Ensures appropriate technical standards and procedures are defined. Manages the development of centers of excellence around key technologies.
- Investigates, initiates, and manages process and cost saving improvement initiatives.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field or equivalent work experience		Required
A Master's Degree in a related field		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
10+ years of experience in	Information Systems (IS), data processing, and data reporting	Required
5+ years of management experience		Required
Other	Prior experience "starting up" and delivering against an Information Systems initiative.	Required
Other	Experience with managing re-engineering and implementation of projects.	Required
Other	Significant project budget management experience, including forecasting, earned value management, and burn rate.	Required

Licenses and Certifications

List professional licenses and certifications associated with this job

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred
Other	Professional certification in IT security or network / systems administration (CISSP, GIAC, MCSE, CCNA, CCIE, others) or IT disciplines.	Preferred

Encounter Data Quality Coordinator

GENERAL JOB INFORMATION

Title: Encounter Data Quality Coordinator

JOB SUMMARY

Responsible for business portfolio management, data management development, encounters submissions, and encounter reporting. Primary responsibilities include developing annual plan aligned to business needs, responding to regulatory requirements, specifying systems supporting value-driven business initiatives; implementing process improvement, enhancements governed by business prioritization committees; coordinate key activities regarding the informatics strategy. Implement costs savings initiatives. Works closely with business partners, IT, Compliance, and Internal Audit.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Responsible for Encounters submissions; ensuring they meet required regulatory and business requirements within acceptable timeframes. This includes organizing and coordinating services and communication between the state plan administration and the state customer for the purpose of identifying, monitoring, and resolving encounter data validation and management issues.
- Serves as the state plan encounter subject matter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter date processing and submissions.
- Annually and throughout the year, works with business partners to align business and Informatics strategies, and establish and maintain a project portfolio.
- Analyze activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
- Sets overall goals, performance standards, and operational priorities for one or more functions and manages resources to operational and financial goals.
- Builds and manages a team of senior managers, managers, other associates, and contractors responsible for the maintenance, support, and development of systems within span of control.
- Collaborates with business partners in the management of vendor relationships which include information technology.
- Works closely with the PCO's and Informatics team to meet all regulatory and business requirements regarding encounter submissions.
- Implements WellCare's data management strategy and data governance standards.
- Works with IT Compliance, WellCare Compliance, and Internal Audit to adhere to all policies and to support audit requirements.
- Works with all business units to improve and enhance data management practices.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field		Required
A Master's Degree in a related field		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
3+ years of management experience	Progressively responsible managerial experience and at least 1 year of managerial experience with similar responsibilities and span of control.	Required
7+ years of experience in	Two or more of the following areas with deep subject matter expertise in at least one area: claims, enrollment, and provider and member data management; health services (care and disease management); and enterprise data management (data warehouse, reporting, and health quality measures such as HEDIS).	Required
Other	Experience in environments with large, complex, real-time transaction volumes	Preferred

Tribal Network Liaison

GENERAL JOB INFORMATION

Title: Tribal Network Liaison

JOB SUMMARY

Manages tribal physician network by developing and maintaining a specific geographic areas. Provides service and education to tribal network physicians/providers. Achieves company targets through the implementation of network improvement plans and provider satisfaction assessments.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Plans and works with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members.
- Serves as the single point of contact with tribal entities and all state customer staff on American Indian issues and concerns.
- Advocates for American Indian members with case management and members services staff.
- Conducts site visits to service providers, resolve issues, educate staff/providers on policies, collect credentialing information, and review HEDIS information.
- Achieves call reach and frequency goals to establish consistent and strong relationship with provider offices.
- Provides oversight on inquiries and claims issues and follows up with providers to ensure problems have been resolved.
- Supports regional Network Improvement Plan targets by providing utilization reports, pharmacy profiles, ER contingencies, Frequent Flier Reports and other analytics available to improve /maintain regions.
- Identifies network gaps and complete contracts or work with Network Development.
- Understands and explains risk contracts.
- Strategizes for membership growth and retention.
  Provides training, mentoring and guidance to new representatives.
- Performs other duties assigned

MINIMUM QUALIFICATIONS

Education

State the minimum required for the job

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in a related field or equivalent work experience		Required

Work Experience

State the minimum required for the job

Experience Level	Experience Details	Required/Preferred
3+ years of experience in	Provider Relations or similar background	Required
1+ year of experience in	Medicaid/Medicare	Required
Other	Pharmacy, healthcare, provider or HMO/PPO background	Preferred
Other	Demonstrated understanding of the unique considerations regarding health care delivery within tribal communities.	Required

Licenses and Certifications

List professional licenses and certifications associated with this job

Licenses/Certifications	Other Licenses/Certifications	Required/Preferred

Pharmacy Director

GENERAL JOB INFORMATION

Title: Pharmacy Director

JOB SUMMARY

Provides clinical pharmacy direction for the state health plan including, but not limited to Medical Economics, Disease Management, Pharmacy, Utilization and Quality Management. Provides drug utilization review. Assists in development of goals and objectives for the clinical pharmacy programs. Serves as resource for drug information. Implements the requirements of the Plan's contract with the state governing agency as it pertains to prescribed drug services and other pharmacy related items for the Medicaid line of business. Assists with the development, presentation, and implementation of policies and procedures consistent with the regulatory requirements of the contract. Oversees pharmacy utilization and produces informative reports to the respective markets in each region. Works directly with the respective Medical Director of each region along with the Medical Economics department to ensure cost effective management of both medical and pharmacy utilization as part of the Network Improvement Program (NIP). Assists in educating clinical pharmacist managers for the region providing information on clinical and trend issues.

ESSENTIAL FUNCTIONS

Note: The following is not intended to be an exhaustive list of all duties required of this position

Key Duties and Responsibilities

- Implements and maintains the prescription drug and pharmacy benefit program.
- Implements and maintains the NIP program specific to pharmacy utilization.
- Leads and coordinates formulary and preferred drug list implementation, evaluation, training, reporting, and problem solving.
- Serving as the subject matter expert on clinical pharmacy and drug product information to support plan benefit design in the point of sale system
- Reviews prescribing practices on high utilizing physicians and intervening as needed providing drug information on pharmacy
- Consults on and coordinates pharmacy program changes.
- Recommends changes in prescribing practices to improve quality and lower costs.
- Oversees, monitors, and assists with the management of pharmacy benefit manager (PBM) activities.
- Reviews pharmacy data to look for savings opportunities.
- Provides clinical pharmacy support for Pharmacy, Disease Management programs, Quality and Utilization Management with an emphasis on Diabetes and asthma.
- Provides in service education to staff including supporting the call center prior authorization function and their development/modification.
- Attend, on behalf of the state plan, the state customer Pharmacy and Therapeutics Committee and DUR Board meetings.
- Meets with the state customer and pharmacy benefits manager at least monthly to discuss operational status updates, including call center, POS system, grievances, and prior authorizations, and review performance standards and restricted services grievances and appeals.

MINIMUM QUALIFICATIONS

Education

Education Level	Education Details	Required/Preferred
A Bachelor's Degree in	Pharmacy	Required
A Doctor of Pharmacy (PharmD)		Preferred

Work Experience

Experience Level	Experience Details	Required/Preferred
7+ years of experience in	a licensed pharmacist role	Required
3+ years of management experience		Required
3+ years of experience in	Supporting formularies, designing prior authorization requirements, and working with clinical information	Required
Other	Experience in managed care	Required

Licenses and Certifications

Other	Licensed and registered pharmacist in state of operation	Required

IV.D STAFFING REQUIREMENTS

19. Describe how the MCO's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, and pharmacy services. *(Page limit 4 pages)*

WELLCARE'S INTEGRATED INFRASTRUCTURE: THE KEY TO SUPPORTING THE WHOLE PERSON

WellCare's administrative and staffing structure, practices and information technology (IT) platforms fully support the integrated delivery of physical, behavioral health and pharmacy services. Additionally, our approach further enhances the integrated delivery of services by seamlessly weaving in social supports and community advocacy activities into our structures and practices. Through our experience with both carved-in and carved-out models of management, we have learned that the best outcomes are produced by having physical and behavioral care management teams integrated and working together side by side on behalf of members.

Administrative Structures that Support the Delivery of Integrated Care

Because of our commitment to holistic and integrated care for our members, we made the decision in 2013 to in-source our behavioral health management. Previously, we had used a third party to manage this aspect of our member's care delivery; however, we found that it did not provide the seamless integration of services to deliver top quality care. We know from our experience that true integration flows from the administrative structure overseeing its delivery. Our medical and clinical staffs (including care management, utilization management, and quality) are structured in such a way that both behavioral and physical clinical services fall under the same clinical services administrative structure but continue to have specialized expertise in their respective fields to meet the individualized and often complex needs of our members.

Our Senior Vice President over Clinical Operations supervises all of our medical leadership including our Chief Medical Director of Quality, our Chief Medical Director of Utilization Management and our Chief Medical Director, Care Management as well as our Vice President for Behavioral Health and Chief Pharmacy Officer. This combined accountability and reporting structure ensures that integration of services begins at the top of our management structure and flows down into our state plans and our service delivery at the member level. Our WellCare of Nebraska infrastructure shows similar layers of accountability with behavioral, pharmacy and physical health staff aligned through the administrative and operational structure.

WellCare's Administrative Structure Supports Pharmacy Integration

For pharmacy, WellCare maintains the clinical aspects of pharmacy management in house, while partnering with a pharmacy benefits manager with decades of experience in claims processing, pricing and network management. Our care managers have access to pharmacy information about our members and the expertise of our in-house pharmacy leadership. This provides our care managers with easily accessible staff to do medication reviews on an individual basis. Likewise, our clinical pharmacy staff can quickly spot trends and adjust our clinical guidelines accordingly

Best in Class: Pharmacy Integration

Working with our behavioral health and medical teams, the pharmacy director in Kentucky led an effort to work with providers to switch members from Suboxone to Zubsolv for treatment of opioid addiction. Zubsolv shows greater outcomes, and the switch is helping our members succeed in their recovery.

An example of pharmacy integration is the role of our pharmacy director in our Kentucky affiliate. There

the pharmacy director works directly with local medical and behavioral health leadership, joining clinical rounds for complex and chronic cases, lending guidance for Step Therapy and helping to control polypharmacy issues which could possibly lead to poor member outcomes.

Our Approach to Integrated Physical and Behavioral Health

Company-wide, WellCare incorporated all behavioral health functions into our health plan in 2013, and launched our long-term supports and services program with fully integrated behavioral health in 2014. Through this complete integration, we are better able to collect and analyze all data associated with a member's utilization, including medical, pharmaceutical and behavioral health care. In addition, we are able to ensure the most appropriate setting of care for members who need both medical and behavioral health services.

As a result of our integrated approach WellCare has developed:

- A single set of integrated, standardized policies and procedures addressing the management of both medical and behavioral health care
- A unified quality monitoring (QM) plan and a single utilization management (UM) plan that address both medical and behavioral health
- An identification and assessment process used to determine our members' holistic health care needs
- A system of care approach to care coordination that includes assessing and offering services for social determinates of health
- An integrated claims payment process for all medical and behavioral health claims integrated within the same IT platform
- A comprehensive Member Services function within our call center that addresses both medical and behavioral health needs
- Consolidated reporting and management of medical, behavioral health finance, and risk.
- Behavioral health reporting that tracks Seriously Emotionally Disturbed (SED) and SPMI Members who have co-morbid chronic medical disorders
- An integrated clinical management platform where staff who specialize in both medical and behavioral health work in the same environment and view all service authorizations together, including pharmacy information

Finally, a key tool to our success is an integrated technology platform which allows for interdisciplinary care management teams, whether co-located or virtual. Through our Medical Management Platform (MMP), we have a comprehensive view of our members across the entire assessment, care planning and service delivery continuum. Through this integrated structure, the member's full spectrum of health care needs is managed and met.

Care Management That Supports Integration

Our care management staff members work diligently to ensure that members with medical and special health care needs are provided the best and most appropriate services available. WellCare care managers work with pregnant women to ensure early and regular prenatal care. For our pediatric members we have a well-coordinated EPSDT outreach and engagement strategy to encourage members to maintain compliance with EPSDT periodicity schedules and visits. For our members with multiple or complex health care needs, our care managers work in an interdisciplinary team approach to identify services across the health and social services spectrum.

Utilizing optimized outcome principles, WellCare supports its members to achieve their full potential by providing access to a comprehensive network of medical and behavioral health providers who offer evidence based treatment services. Our behavioral health care managers partner with community behavioral health and medical providers to coordinate care and facilitate treatment needs for members.

Care managers coordinate the medical, behavioral, and social service needs of their members through assessment, care planning, implementation and monitoring. WellCare's field-based quality improvement team will monitor quality for all care managers, members and providers throughout the system. In addition, we know that our members often face barriers to good health and recovery that go beyond services in a traditional health coverage benefits package.

Leveraging Our Health*Connections* Model to Integrate Social Services into our Members' Care

To supplement traditional managed care coordination, WellCare uses the Health*Connections* Model to identify the available social safety net providers within the WellCare footprint, assess the critical service gaps (existing and potential) and identify ways to sustain the network of the social safety net.

This collaboration with local agencies ensures that our members have access to services to address social determinants of health such as food, housing, and educational opportunities. For us, integrated care includes medical, behavioral, pharmacy *and* social service coordination of service delivery. We believe that integrating this piece is essential for our members' lives to truly improve.

To facilitate our member's access to our plan and benefits, WellCare will place field-based teams working out of our Lincoln headquarters, as well as our Welcome Rooms located in Omaha, Kearney, Scottsbluff and Norfolk. These Welcome Rooms will offer local access to service and support for our members, providers and community partners. At times, these Welcome Rooms may be co-located with a social service safety net provider. Strategic placement of these resources across the state maximizes our responsiveness to members, their caregivers and our provider network and increases the integration of their care. Members, their families and providers will be encouraged to visit their nearest WellCare of Nebraska office, which will offer onsite member and caregiver support, chronic care management classes, member services and provider education.

Community partnerships reach beyond the agencies/organizations that will be sharing responsibility for care management. When we need additional partners to further enhance the benefits to our members, we will support other Nebraska-based organizations for their expertise and community ties.

MEMBER STORY

Screening for Behavioral Health Needs in Primary Care: Integrated Teams Improve Member Outcomes

- A registered nurse with our Georgia affiliate, WellCare of Georgia, who was part of a member's integrated care team, was providing care coordination for the member's medical condition. Having been trained in the high rate of co-occurring depression for individuals with serious and chronic medical conditions, she administered a PHQ-9 and identified that the member screened positive for major depression. The nurse referred the member to a Behavioral Health Case Manager (BHCM) for a comprehensive assessment.
- The BHCM completed a face-to-face assessment and created a safety plan that incorporated the use of natural supports, including the member's sister. The BHCM coordinated care with a behavioral health specialist to secure an immediate appointment with a community-based Provider, Genesis Alliance for Mental Health, which provides comprehensive, community-based, recovery-oriented services including Intensive Day (Partial Hospitalization) Programs, Assertive Community Treatment and Psychosocial Rehabilitation to help individuals remain safely in the community. While the assessment was being scheduled, the BHCM kept in contact with the member to ensure that the safety plan was followed.
- Because the case manager was trained to recognize the importance of screening in both primary care and behavioral health settings, the member received behavioral health supports and services in addition to treatment for a medical condition. Our integrated approach to addressing the continuum of member needs fosters this holistic approach to care.

Additional Strategies for Integrating Physical and Behavioral Health

Strategies and processes for facilitating the reciprocal exchange of health information between physical and behavioral health providers that are active and will be implemented in our Nebraska program include the following:

On a monthly basis we use data to identify members who have behavioral health needs and one or more serious physical co-morbidities. This report identifies members and queues them up for immediate triage, assessment and referral into our care management program. We actively coordinate for members who are currently in a provider-based (Integrated Health Home or Patient Centered Medical Home) care coordination program. For these members, we send the relevant clinical data to the health home care management team so that follow-up can be made and treatment plans can be updated with the latest clinical information.

For members identified with medical/behavioral comorbidities we share with treating providers the data- either through our care managers or through regular feedback and reports periodically given to our high-volume providers.

Additionally, we have a monitoring system for behavioral health providers that focuses on high-volume providers and outliers (with relation to under-utilizers or over-utilizers). We meet with behavioral health providers who are identified as outliers to gain a better understanding of the particular population they serve and partner together to identify opportunities to improve the quality of care for our shared members.

Some, not all, behavioral health providers are given a performance report card if they are identified as outliers. We meet with those providers face-to-face, and when indicated a corrective action plan is requested. Our provider relations team, along with the behavioral health operations and quality improvement team, all have a part in monitoring of providers. A similar process is in place for medical providers.

IV.D STAFFING REQUIREMENTS

20. Describe how the MCO 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. *(Page limit 6 pages)*

DEVELOPING INTEGRATED TRAINING WITH A FOCUS ON SOCIAL DETERMINANTS OF HEALTH

WellCare has a one-of-a-kind approach to helping members navigate social services and supports, so our associates have access to a unique set of tools and skills focused on getting members referred to the right resources at the right time. In addition to training our staff, we recruit, hire and retain associates through our Workforce Diversity and Inclusion program who have similar backgrounds as our members. This diverse workforce fosters an even greater level of trust and compassion between our associates and our membership. Increasing knowledge and fostering empathy among our associates for our members are the driving values behind our training programs.

Our systematic recruitment process is highly selective and ensures that experienced, well-trained personnel will support implementation and ongoing administration of the Nebraska contract. Candidates are sourced and placed via a robust, multifaceted talent acquisition search. To ensure our plan is oriented toward the local needs of members, we will proactively look for Nebraskans to staff those positions that are based in Nebraska. All prospective candidates are vetted via a multi-step, behaviorally-based interviewing program. Final candidates undergo an extensive background screening process that validates education, experience and credentials via an independent third party vendor. This background screening process is consistent for both full time (W-2) employees as well as subcontractors.

Once hired, WellCare offers a thorough associate onboarding process which equips each new WellCare associate with a well-rounded perspective on the organization, the populations we serve including the complex life circumstances of our members, and the aspects of that particular associate's new role.

Creating New Training Curricula for Associates

WellCare's Enterprise Learning and Development department includes a team of professional instructional designers who create new training modules specific to each market we serve. Content for these training modules is developed in accordance with the regulations and characteristics of that market. Recent examples include curriculum designed for our New Jersey MLTSS expansion and New York Behavioral Health. To create new training modules, a professional instructional designer serves as both consultant and producer of effective, state-specific training modules.

Incorporating CommUnity Knowledge in our Training Curricula

For Nebraska, WellCare will develop training modules which provide all staff with an in-depth understanding of the populations, care coordination needs and regulatory requirements specific to Nebraskans. This training supplements standard training offered, and it will include training around social determinants of health – how to recognize need and make referrals to care. Through our CommUnity advocacy program we have quantified the role that community service organizations play in supporting our members in their local communities. We blend that national knowledge with the robust knowledge we have gleaned from our on the ground experience in Nebraska cataloguing and interacting with community services organizations. For example, all associates who will attend directly to member's needs are trained on how to refer members to our Community Assistance line where the member can be referred to access needed resources such as food, shelter and crisis intervention.

Content Development for Training: Targeted, Timely, and Responsive

An agile training curriculum capable of responding to evolving learning needs via rapidly redefined content is a critical component of our training program. Our content provides both baseline training and training targeted to address new programs, programmatic and business process changes.

Programmatic changes are conveyed timely to all staff via a variety of communication vehicles and integrated into materials that support new hire orientation and onboarding. All departmental team leads are charged with initiating a training request when a programmatic change occurs in his or her area. When a team leader becomes aware of a programmatic change, he or she submits a training request to our Business Training Intake Request system. The Training Request prompts the team leader to specify details about the need for training, including type of training (new or updating of information), impact to the organization and value to different staff members.

One of our training managers performs intake and triage of each request, including contacting the requester to discuss and ensure an understanding of the scope of the request. By using a triage method for training requests, our training department can rapidly respond to regulatory changes or other such changes as directed.

Staff training is delivered through a blended learning strategy which incorporates instructor-led classroom training, computer-based training modules, and virtual learning via webinar. In addition to Nebraska-specific modules, training content is comprised of enterprise curriculum on a wide range of topics such as HIPAA, member advance directives and key tools and systems. All training curricula incorporates a two-pronged learning assessment methodology.

Once the training request is validated, the training manager initiates a training material modification that adheres to the ADDIE Training Model (Analysis, Design, Develop, Implement and Evaluate).

- **Analysis:** During Analysis, the training manager identifies and validates impacted staff, departments and artifacts, and the changes that need to be communicated and made, as well as the requisite timeframe.
- **Design:** During Design, the training manager designs curriculum and determines the best method for conveying that curriculum to the designated audience(s). Methods for communicating programmatic changes to staff include:
  - Instructor Led Training
  - Virtual Instructor Led Webinars
  - Web Based Training
  - Information Distribution via existing forums (e.g. staff meetings, town halls)
  - Dedicated written communications (e.g. email, intranet updates)
- **Development:** During Development, the training manager develops new or makes changes to training materials and develops ancillary communications. During this phase, the business training manager also develops the methods by which the training will be monitored and evaluated.
- **Implementation:** During Implementation, the training manager completes the tasks necessary to deploy the training to the designated audiences via the appropriate methodology, including: instructor led training, deployment of new or updated computer based trainings, updates to web content or distribution of memoranda or other written artifacts. Implementation includes monitoring for compliance targeted at certifying that all designated staff and departments have participated in training, and all affected baseline artifacts are updated and incorporated into the training asset repositories for use during onboarding of new staff.
- **Evaluation:** During Evaluation, the training manager completes evaluation of the training plan for the designated change. A recent example of a request submitted to the Training Intake Request system dealt with changes to necessary staff knowledge and competencies related to behavioral health

conditions and substance use in high-risk pregnancies. As a result of the ADDIE process, the business training manager facilitated the development of a newly required web based training module. The project required development of the training module itself as well as updates to policies and monitoring systems to ensure the staff mandated to complete the training module are assigned the training, and that their managers monitor completion.

All WellCare associates and subcontractors who will bear any responsibility in the execution of commitments made in this RFP response will be required to complete a detailed training program specific to the population in Nebraska. This training will include teaching associates how life circumstances such as poverty, homelessness, domestic violence, and mental illness affect the population we serve. Further content for the training modules will be developed in accordance with the regulations, eligible populations and characteristics of the Nebraska RFP Number 5151 Z1.

Recent examples developing new training curricula include the New Jersey MLTSS expansion and our participation in New York's Fully Integrated Duals Advantage (FIDA) program. In both instances, a trained instructional designer served as both consultant and producer of effective, state-specific training modules.

Be Ready Training and WellCare University

WellCare places the highest value on effective associate onboarding and training. While associate satisfaction and retention are important byproducts, the most important results of our training investment are reflected in the service received by our members and providers.

To effectively support our new associates, WellCare has developed a comprehensive learning and development strategy called "BeReady." BeReady is comprised of two key elements – a role-specific training agenda, which we call a Learning Roadmap, and a corresponding Learning Plan which provides opportunities for hands-on mentoring and supervision in a live environment.

Beyond initial new hire training, associates and subcontractors are required to complete annual regulatory compliance training. Continuing education in new benefit designs and service areas occur annually, and changes to any operations or regulatory requirements occur as warranted by the change.

WellCare also offers open access to nearly 2,000 courses for all of our associates through our learning management system from industry-leading Cornerstone OnDemand, which is internally branded as WellCare University. While initial training development and delivery will be managed by a Tampa-based training team, WellCare of Nebraska will hire and equip a professional training team to be based in Lincoln for ongoing associate development.

MEMBER NEEDS DRIVE OUR TRAINING

Preparing Associates to Recognize and Help Solve for Member Needs

We know that our members face an array of difficult life circumstances from food and housing concerns, to violence and domestic abuse. These circumstances dictate their health, and our associates must be prepared to identify areas of concern and provide the member with resources for dealing with the situation. At WellCare, we have a two pronged approach to this complex problem. The first is our CommUnity engagement model which identifies community social supports and links our members to these vital programs.

CommUnity Liaison Program

WellCare created a new department to research and catalogue available social services across the United States. This team is hired through Workforce Innovation programs like Ticket to Work, Welfare to Work, Military/Veteran and student worker programs and so on. In September 2014, WellCare launched social

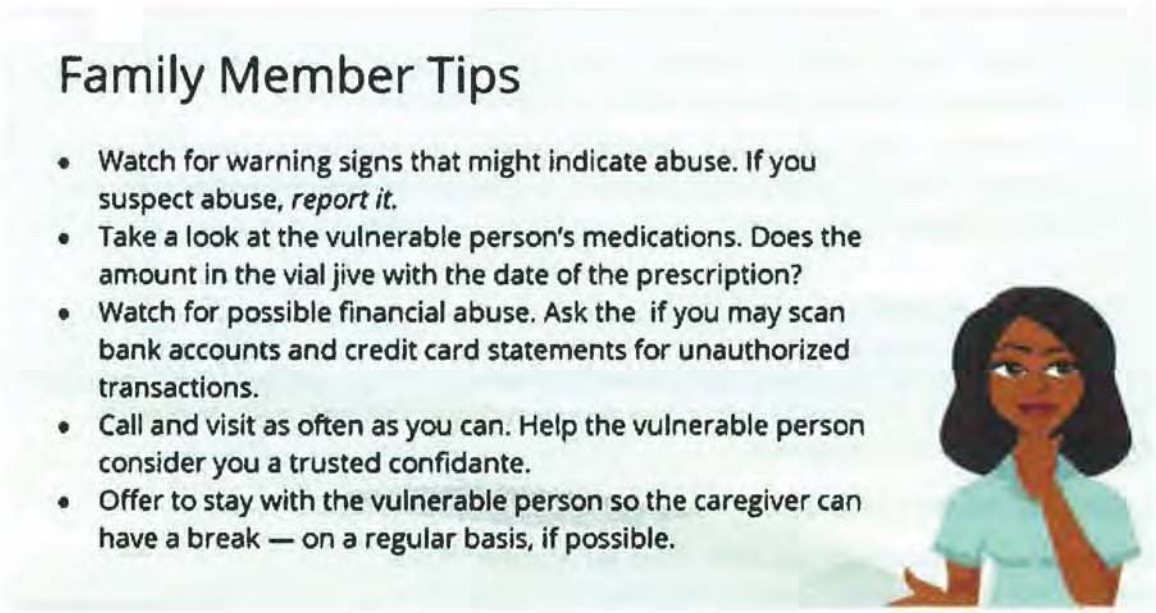
service resource line for members, their families and the community-at-large. CommUnity Liaisons help callers find and access community-based programs and services in their local area. Since launching, the CommUnity Assistance Line team connected more than 4,000 callers to 5,300 organizations for 17,000 services.

WellCare maintains a social service electronic health record (SSEHR) on each caller. This SSEHR maintains information on the organizations and the services to which our teams refer members and callers plus the disposition of their referral. This information is aggregated and released on a monthly basis along with details about the social service network itself. In addition, the Advocacy & CommUnity Based Programs department works closely with the clinical teams in each market to infuse feedback from the Health*Connections* Model into the clinical and quality operations as well as messaging used to educate our associates. For example, in 2015, WellCare launched an internal campaign highlighting the unique social barriers of our members, their families and the community-at-large.

Training Associates to Recognize Risks to Our Most Vulnerable Members

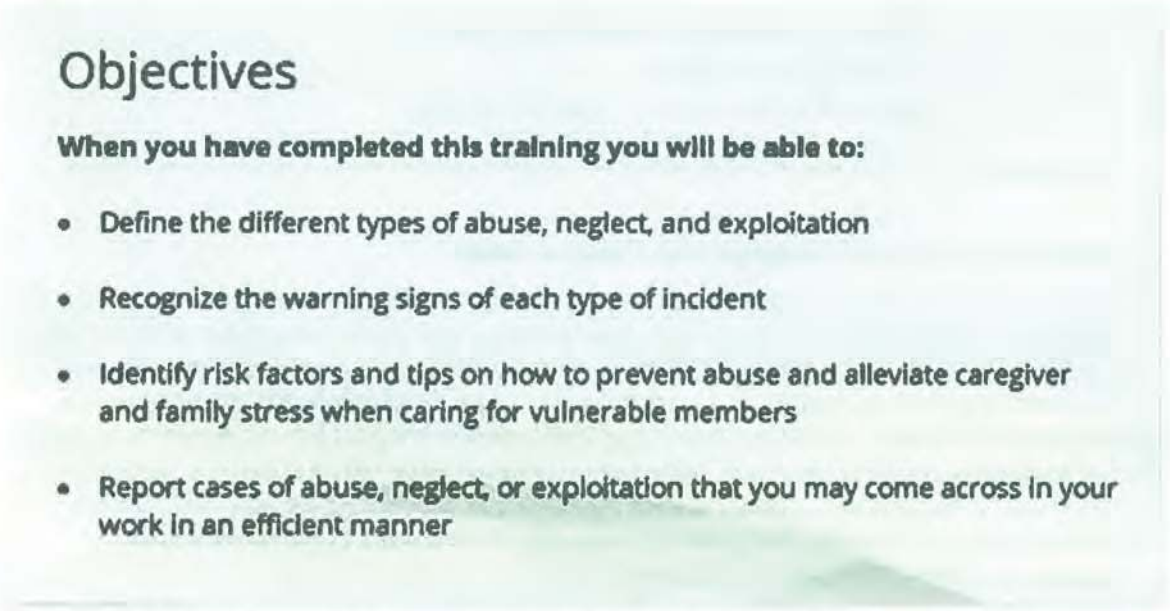
Our second strategy is the training we provide our associates to identify members who are at risk in their own homes. For example, as part of one of our new hire trainings for clinical services, associates are taught to spot abuse for vulnerable members. In this slide (**Figure 5**) care managers are trained on how to help family members who may be overwhelmed providing care to their sick or infirm family member.

Figure 5



The overall objectives are listed in **Figure 6** below:

Figure 6



This type of training occurs for all of our clinical services personnel and is enhanced for those associates who will be handling situations in which behavioral health needs of the member are high. Other training emphasizes how associates may refer caregivers to respite resources that we have identified through our CommUnity advocacy program.

Special Populations Additional Training

For associates who will interact with members who have behavioral health needs, additional training is provided. For example, our medical care managers are cross trained to collaborate with their behavioral health counterparts and vice versa. Our behavioral health director offers a weekly, "Doctor Is In," program in which case managers are invited to ask behavioral health questions and problem solve difficult cases as a group. Behavioral health care management and utilization management positions are filled with associates who have extensive training in behavioral health such as psychologists, LSCWs and licensed marriage and family therapists. As part of our utilization management ongoing training for both medical and behavioral health care managers, there is also a quarterly refresher training course which is mandatory for all associates.

As an example of topics addressed in our behavioral health training in our New York affiliate, associates receive the following training (**Figure 7**) on an ongoing basis:

Figure 7

AN EXAMPLE: WELLCARE OF NEW YORK ONGOING TRAINING	
Monthly	Modules available for skill enhancement and refresher training to ensure Associate Success. ➢ Transitioning Aged Youth ➢ Assisted Outpatient Treatment, AOT ➢ NY *Specific* Cultural Competency ➢ An Integrated Approach to COPD ➢ An Integrated Approach to Treating Heart Disease ➢ Integrated Care of Diabetes Mellitus

	➢ An Integrated Approach to Managing Sickle Cell Disease ➢ An Integrated Approach to Asthma ➢ Behavioral Health Conditions in High Risk Pregnancy ➢ Substance Use Disorders in High Risk Pregnancy ➢ Fostering Behavior Change
Quarterly	➢ Behavioral Health Program - 4 Quadrant Strategy ➢ BH Clinical Policy

WellCare's Diversity & Inclusion Program: Our Values at Work

By undertaking measures to foster an inclusive environment, WellCare actively reflects the communities in which it operates and populations for which it provides services. The overarching goals of WellCare's award-winning Diversity & Inclusion (D&I) Program are to strengthen our interconnectivity with our diverse communities. WellCare embarked on a workforce innovation initiative in 2013that focuses on four key complementary elements including identifying opportunities to adjust job requirements to enable participation in workforce incentive programs, targeting recruitment efforts around diverse candidates, and incorporating D&I principles and communication methods into onboarding for new associates. As a result, WellCare created 4 pilots which have now grown and become standard operations within the company including the CommUnity Liaison Program.

Our members are our reason for being. Training our associates to serve them in an informed and compassionate manner is at the heart of our training curricula. We created a culture of inclusion and understanding through our formal training modules which address the challenges our members often face. In addition, we have changed our corporate culture by recruiting and hiring associates from similar backgrounds as our members.

IV.D STAFFING REQUIREMENTS

21. Describe how the MCO will coordinate with the MLTC Dental Benefits Manager, including processes for reciprocal referral for needed services. Include the MCO's plan to identify a dental services liaison. *(Page limit 2 pages)*

BUILDING PARTNERSHIPS AND EXPERTISE: OUR APPROACH TO COORDINATING DENTAL BENEFITS

WellCare has extensive experience coordinating care with entities that have a special expertise in managing dental benefits for Medicaid members. Either through our own contracts or through "carved-out" programs like that being developed for Heritage Health, the basic processes remain the same and include designated staff, training, member education, data exchange and facilitation of referrals and follow-ups. We believe we can serve as an asset to MLTC's contracted Dental Benefits Manager by leveraging the power of primary care physicians (PCPs), particularly within the Patient-Centered Medical Home (PCMH) framework of Nebraska, to facilitate strong preventive care and referral to ensure members get the oral health care they need.

Best in Class: An Example

Our affiliate, WellCare of Georgia, is the leader among all care management organizations managing Medicaid populations for annual dental visits.

To facilitate the coordination of oral health care benefits with our members, and the MLTC–selected Dental Benefits Manager, we are going to designate one of our care coordinators to be the liaison between the Dental Benefits Manager and WellCare. We have chosen to locate this function within the scope of our care management program because we know it will promote integration and coordination of all the pieces of the member's overall health. The designated liaison will serve to continually educate colleagues on how to make referrals to the Dental Benefits Manager and ensure the lines of communication and referral processes between our two entities remain productive. We would support a multi-payer effort to streamline the referral process and would be eager to work with MLTC to help develop the forms and necessary business agreements to make reciprocal referral effective and efficient.

One of the critical tools we use in many states to help the children we serve maintain good oral health care is the EPSDT periodicity schedule and care gap identification. In a carved-out model, we would use data provided by our state partners to help populate this effort. We view our relationship with the state and the dental service provider as a symbiotic one wherein we are all utilizing the information available to ensure the member receives all necessary services.

Because pediatricians often have the closest relationships to families, we believe it's critical to empower PCPs to help drive dental referrals. To do this, we communicate with and secure commitment of network pediatricians and PCPs to support our efforts in ensuring that our Members access EPSDT and dental services according to national clinical practice guidelines. Our network Providers are fully committed to continue to engage in our EPSDT program, educate our Members about preventive health, and make the appropriate referrals to dental care Providers.

Helping the Dental Benefits Manager Reach Members: Education and Outreach

Another way we can help coordinate care and partner with the Dental Benefits Manager is to leverage our member connections to share critical information and education around oral health care.

- **Initial Engagement:** Should the state have a Dental Benefits Manager selected during initial implementation, we will include information about how to access those services in our initial welcome materials.

- **Periodicity Letters:** WellCare identifies members having a birthday who are due for age-appropriate screenings and assessments according to the EPSDT periodicity schedule. WellCare mails them an age-specific letter informing them of the recommended screenings and services, including dental services and follow up on dental referrals.
- **Newsletters:** We will mail quarterly newsletters to members and can use those opportunities to do periodic reminders about accessing dental health benefits.
- **Member Awareness and Education via Digital Media:** Our health and wellness Member portal provides parents and children with helpful, age-appropriate information about a variety of health topics including annual dental visits (**Figure 8**). Our Healthy Kids and Teen Member Portal provides educational tools and resources. For parents, we offer an extensive library of articles, frequently asked questions (FAQs) and fact sheets. In addition, our mobile application for Smartphones and mobile devices, MyWellCare, provides friendly, timely alerts when Members are due for check-ups.

Figure 8

WellCare has also developed community-based strategies to increase oral health awareness as well as increase access to care by addressing social barriers. In 2014 WellCare accomplished the following across 12 different states:

- CommUnity Activities
  - Hosted or participated in 228 total activities related to oral health reaching nearly 14,000 children and families.
  - Collaborated with more than 31,000 community stakeholders related to increasing access to dental/oral health services within the community.
- Social Service Utilization Support
  - Bridged more than 43 gaps in needed free or reduced dental/oral health support.
- CommUnity Health Investment Program
  - Partnered with Help a Child Smile to bring a community-based mobile dental clinic to an area of rural Georgia with limited access to dental services. The program was located at a local school to increase EPSDT compliance with regular dental checkups for all children, including WellCare members.

IV.E COVERED SERVICES AND BENEFITS

22. Provide the MCO'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 pages)*

DEFINING MEDICAL NECESSITY: A FOCUS ON ENSURING MEMBERS GET THE RIGHT SERVICES

WellCare's definition of medical necessity and our review criteria are predicated on our mission to support and engage members and providers, improve access and outcomes, inform clinical care, and maintain our role as stewards of government-funded resources without delaying or compromising care. With that in mind, our medical necessity definition, clinical practice guidelines and utilization management (UM) processes are designed to deliver efficiencies while mitigating the impact on network providers and members.

Through our experience serving Medicaid members in urban, rural and island areas across nine states, we are well positioned to effectively apply the criteria and guidelines in a manner that considers the complexities of the Medicaid population including considerations for individual factors (i.e., age, comorbidities and complications, etc.) as well as the local Nebraska delivery system and the availability of services. ***Our member-centered approach to medical necessity determinations means that medical necessity may supersede benefit coverage unless services are specifically excluded.***

Based upon generally accepted medical practices in light of conditions at the time of treatment, WellCare defines *medically necessary* as those services that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the provider
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's Evidence of Coverage

There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

For Medicaid children under 21 years of age, WellCare will provide medically necessary services to correct or ameliorate physical and behavioral health disorders, a defect or a condition identified during an Early Periodic Screen, Diagnostic and Treatment (EPSDT) screening or preventive visit regardless of whether these services are included in the State Plan, but are otherwise allowed pursuant to 1905(a) of the Social Security Act.

MEDICAL NECESSITY REVIEW AND REVISION PROCESS

Written, Evidence-Based Guidelines and Criteria

In making medical necessity determinations, WellCare applies written, evidence-based guidelines and review criteria to ensure members receive the right care, at the right time and in the right setting. Guidelines and criteria are vitally important decision support tools which ensure medical necessity decisions are based on sound clinical evidence. They also enable fair, impartial and consistent decision-making. By evaluating requests against nationally accepted, evidence-based guidelines, WellCare assists providers in determining the most appropriate treatment and services for our members, avoiding

unnecessary duplication of services, and appropriately managing utilization to mitigate both under-utilization and over-utilization of services. These actions result in optimal health outcomes for our members in a quality, cost-effective, efficient manner. Our guidelines and criteria include:

- InterQual® Clinical Guidelines
- Behavioral Health Guidelines
- CareCore® National Guidelines
- Apollo® Guidelines
- Pharmacy Guidelines
- Clinical Coverage Guidelines
- Hayes Health Technology
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Medicare Local Coverage Determinations

WellCare will apply these guidelines along with the Nebraska Medicaid State Plan, the Nebraska Children's Health Insurance Program (CHIP) State Plan, and MLTC's definition of medically necessity per 471 NAC 1-002.02A. All decision support tools will be applied in a manner that is customized for the complexities of the Heritage Health population including considerations for individual factors such as age, comorbidities, complications, progress, psychosocial situation, home environment, the local delivery system and the availability of services.

Adoption and Implementation of Guidelines

Our guidelines and criteria are reviewed and updated annually and as needed in accordance with the specific guideline policies, review schedules or changes from professional societies and oversight bodies. Prior to implementation, our medical and behavioral health (non-pharmacy) guidelines and criteria will be reviewed and approved by the following WellCare committees:

- **Medical Policy Committee:** WellCare's corporate Medical Policy Committee (MPC) meets monthly to identify and approve new and updated guidelines and review criteria. The (MPC) is chaired by our corporate Vice President for Clinical Services Management and includes WellCare's corporate and state medical directors.
- **Clinical Advisory Committee:** Our Clinical Advisory Committee (CAC) will be comprised of individuals who care for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, have an awareness of differences between urban, rural, and frontier populations and represent pharmacists, physical health providers, and behavioral health providers. The CAC will review and approve WellCare's initial practice guidelines and criteria as well as all significant changes to the guidelines thereafter.
- **Pharmacy and Therapeutics Committee:** Our pharmacy guidelines are reviewed and approved by WellCare's corporate Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is chaired by our Senior Medical Director of Pharmacy and is comprised of both WellCare and independent practicing physicians. Once guidelines are approved, they are integrated into our clinical systems and processes. Staff members are trained accordingly and the guidelines are disseminated through the provider portal, via the website and communicated through individual authorization decisions.

CONSISTENCY WITH MLTC DEFINITION OF MEDICAL NECESSITY

WellCare has reviewed the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) definition of medical necessity per 471 NAC 1-002.02A and has found that our definition is no more restrictive than MLTC's definition. The following table (**Figure 1**) compares the two definitions and illustrates alignment:

Figure 1

MEDICAL NECESSITY		
Comparison of Definitions		
MLTC Definition	**WellCare Definition***	**Alignment**
Necessary to meet the basic health needs of the client	Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition	✓
Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service	There must be no other effective and more conservative or substantially less costly treatment, service and setting available.	✓
Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;	Compatible with the standards of acceptable medical practice in the community	✓
Consistent with the diagnosis of the condition	Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition	✓
Required for means other than convenience of the client or his or her physician	Not provided solely for the convenience of the member or the convenience of the provider Not primarily custodial care unless custodial care is a covered service or benefit under the member's Evidence of Coverage	✓
No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency	Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms	✓
Of demonstrated value	Compatible with the standards of acceptable medical practice in the community	✓
No more intense level of service than can be safely provided	There must be no other effective and more conservative or substantially less costly treatment, service and setting available.	✓
**Comparable WellCare medical necessity definitional language underlined*		

SECOND OPINION

Consistent with MLTC requirements, it is WellCare's policy to provide our members the right to a second surgical and/or medical opinion in any instance when the member disagrees with his or her physician's opinion of the reasonableness or necessity of surgical procedures, or when the member is subject to a serious injury or illness. The second surgical and/or medical opinion, if requested, will be provided by a physician chosen by the member who may select from a qualified health care professional within the network, or we will arrange for the member to obtain one outside the network, at no cost to the member. Our pharmacy program offers an appeal process for all denied prior authorizations and if necessary, an outside expert is used in rendering a decision.

IV.E COVERED SERVICES AND BENEFITS

23. Provide a description of the value-added services the MCO proposes to offer to members. 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 MCO will identify the expanded benefit in administrative or encounter data.

IMPROVING HEALTH OUTCOMES THROUGH VALUE-ADDED SERVICES

WellCare provides a holistic and person-centered approach to member care through a variety of innovative valued added services that are designed to improve the health and wellness of members by increasing their access to comprehensive health services in a cost-effective manner. These services and benefits address member needs and contribute to improvement in quality outcomes by removing barriers to care and enhancing quality of life.

Determining Value-added Services

WellCare will utilize our field-tested continuous development process for value-added services that begins with research, outreach, and needs assessment and continues throughout implementation including continuous solicitation of member feedback and evaluation. This five-step process (**Figure 2**) is described below:

Figure 2

Research and Needs Assessment

The value-added services and benefits that we will implement in Nebraska and propose to deliver under the Heritage Health contract have been developed through significant collaborative efforts with stakeholders and community based organizations in Nebraska as well as our research and thorough understanding of the Nebraska Medicaid

Figure 3

WellCare Value Added Services
Reducing Non-Emergency use of the Emergency Department through Increased Access to Services
Emergency Department Diversion Program
Supplemental Transportation
24-Hour Behavioral Health Crisis Line
Telemonitoring Diabetic Management System
Mail Order Pharmacy
MyWellCare application
Focused Homeless Initiative
Improving Birth Outcomes through Prenatal, Postnatal, and Inter-Pregnancy Care
Prenatal Care Management Program
Community Baby Showers
Stroller/Portable Playpen Program
Doula Services for Pregnant Youth
Coordinating and Integrating Prevention-focused Physical and Behavioral Health Services
Comprehensive Peer Support Program
Family Support Specialists
COBALT Therapeutics
Foster Care Transition Services
Improving Overall Health and Wellness
Health Rewards Program
Hypoallergenic Bedding Allowance
Weight Watchers
Over the Counter (OTC) Benefits
Discount Card
Tobacco Cessation Program
Improving Health Outcomes through Community Engagement
Welcome Rooms/Concierge
Health Fairs
WellCare Days
Mini Farmer's Markets
Health*Connections* Activities

population and barriers they face in accessing care. **Between September and November of 2015, WellCare Community Relations associates met with community based organizations around the state to identify health, social, cultural and economic needs of the communities and members we will serve in Nebraska,** including the health disparities present in the Heritage Health population and the community at large.

Development and Organizational Readiness

Based on our initial research and assessment of Heritage Health members' needs, WellCare designed the value-added services package described in **Figure 3**. We also reviewed our proposed value-added services to ensure that we have the platforms, systems, and human resources needed to provide these services and do so in a culturally competent manner specific to Heritage Health members' needs. The development phase will also include, in collaboration with MLTC, identification of evaluation metrics to determine the success of value-added services.

Program Deployment

WellCare will implement these valued added services to improve the health and wellness of members. Implementation of value-added services and programs will link WellCare members to community resources, enhance cultural and linguistic capabilities of our provider partners, and educate members so that their experience with the health system is more positive and their health outcomes are more favorable.

Member and Provider Feedback

WellCare will gather information from members and providers through written and oral surveys, online forms, emails, letters, or phone calls. The information received will be an important resource for improving and addressing the needs and wants of our members and providers through value-added services.

Evaluation

Using the metrics identified in the development phase, WellCare will collect data annually to identify its progress towards success as well as opportunities for ongoing process and quality improvement. As

determined through our evaluation efforts, WellCare may make additions, deletions, or modifications to our value-added services during the contract period and will submit such changes for approval to the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) a minimum of 45 calendar days prior to implementation.

WellCare's Value-added Services

We have grouped our value-added benefits and services into five areas (as shown in Figure 2) tailored to specifically address Nebraska's population-specific needs and health outcome goals. We believe these value-added services will deliver meaningful, lasting improvements for our members thereby delivering value to our Providers and MLTC. Our value-added benefits are developed to go above and beyond MLTC's required covered services and are designed to ensure care is delivered holistically. Below, we define and describe the valued added services and provide details regarding member eligibility, limitations, access and the provision of services, and how members and providers will be notified of the service.

Reduction in Non-Emergency use of the Emergency Department through Increased Access

The issue of inappropriate emergency department (ED) use is complex, requiring a multi-disciplinary and multi-pronged approach. We propose a suite of valued added services (**Figure 4**) that seek to substantially improve members' continuity of care, health outcomes and quality of life while reducing cost and inappropriate ED use. We will leverage our experience implementing ED diversion programs in other states and include other services and supports to reduce barriers to care, including the following services:

- Emergency Department Diversion Program
- Supplemental Transportation
- 24-Hour Behavioral Health Crisis Line
- Telemonitoring Diabetic Management System
- Optional Mail Order Pharmacy
- MyWellCare Mobile Application
- Focused Homeless Initiative

Figure 4

EMERGENCY DEPARTMENT DIVERSION PROGRAM	
Description	Through our emergency room diversion processes, we help reduce Emergency Department (ED) expenditures by identifying and educating members who unnecessarily or frequently and inappropriately utilize emergency room services. This begins by identifying members who over-utilize ED services. Our Care Management team contacts the member, conducts a telephonic assessment to determine underlying issues that drive inappropriate ED use, and connects the member to the most appropriate, cost-effective services and resources for their condition. These services are typically provided by the patient's primary care physician or a specialist as necessary. Throughout the process, a care manager communicates with the member regularly, encouraging primary care physician visits and relationships. Follow-up is also provided to ensure the patient keeps their scheduled appointments. Re-education is also performed when necessary.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Care Managers

Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
SUPPLEMENTAL TRANSPORTATION	
Description	WellCare will cover the cost to reimburse families and friends who provide supplemental transportation to members to their doctor appointments. With this expanded benefit, members can focus on getting the care they need without concern of financial barriers to care. Millions of Americans miss or delay non-emergency medical care each year because they have no way to get there. Numerous studies prove increasing transportation access to medical services results in significant savings. Transportation is inexpensive compared to the high and rapidly growing cost of health care, making it more cost-effective to transport a member to preventative care rather than waiting for a serious health condition to arise. This value-added service will supplement the Heritage Health non-emergency transportation benefit and will address a significant barrier to access to getting Medical care.
Eligible Members	All members
Limitations/Restrictions	Medically necessary/Requires prior authorization
Responsible Providers	Transportation management vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
24-HOUR BEHAVIORAL CRISIS HOTLINE	
Description	WellCare will provide members with access to a 24-hour behavioral health crisis line. Should a member contact the 24/7 behavioral health crisis line, the call will be answered by a specially trained, non-clinician, within established time frames for call handling. If the call is a true crisis call, a behavioral health clinician will immediately join the call to assess, support and manage the situation for the most timely and effective outcome for the member in need. Crisis calls will be triaged and the appropriate intervention will be arranged based on the member's needs, logging the call for submission to WellCare via secure network access. Depending on the situation, the law enforcement and ER avenues are avoidable. The expected outcome of this model is a decrease in unnecessary ER visits and BH hospitalizations. Foster children and their caregivers have access to this service from WellCare of Kentucky.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	Behavioral Crisis Hotline vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.

Reporting	WellCare will use existing service codes to identify service in administrative data.
TELEMONITORING DIABETIC MANAGEMENT SYSTEM	
Description	WellCare will provide telemonitoring diabetic management through a system that connects patients to their provider and family through a cellular-enabled device. This system aims to aid and assist all individuals that live with diabetes in day-to-day lifestyle and condition management to help them stay out of critical care and higher risk categories. It actively supports individuals living with diabetes while removing barriers to managing their condition successfully. It is both a patient engagement tool and a cellular-enabled blood glucose meter. The system allows members the unique ability to measure their blood glucose, which automatically triggers the transmission of the data to a WellCare nurse, the members' provider, and/or caregiver. It also provides member feedback messages after each test, which is an ideal opportunity for members to receive feedback designed to inspire, encourage, educate, and support the member in best-practice self-management behavior.
Eligible Members	All diabetic members meeting medically necessity
Limitations/Restrictions	Requires prior authorization
Responsible Providers	Telemonitoring vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
OPTIONAL MAIL ORDER PHARMACY	
Description	Adequate usage and obtaining required prescription drugs is vital to ensuring that our members are appropriately managing their health care. WellCare will provide a voluntary mail order pharmacy option to address the challenges faced by members who live in rural areas and may not have a pharmacy that is close by, those with transportation constraints, or those impacted by health care issues that make it difficult to leave their homes—in turn making them at risk for not obtaining their needed medications. Members will still have the ability to access the traditional use of the local pharmacy and obtain prescriptions through this method. The mail order pharmacy supplements the current process by offering our members of varying needs an option to relieve any of the barriers described above and manage their pharmacy health care needs as appropriate.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	Pharmacy Benefits Management (PBM) vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.

Reporting	WellCare will use existing service codes to identify service in administrative data.
MyWellCare Mobile Application	
Description	WellCare makes it easy for members to interact with us when and how they want. Heritage Health members will be able to download our *MyWellCare* application to their Apple or Android device to have easy access to their member ID Card, Find-a-Provider tool, Quick Care (urgent care and hospital services locator), Contact Us and Wellness Services, which include care gaps.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	*MyWellCare* application vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare tracks and will report the number of times the application has been downloaded.
Focused Homeless Initiative	
Description	WellCare will collaborate with local community based organizations to create additional services such as behavioral health assessments, parenting support, group therapy, nutritional education and medical access that impact retention rates and wait times of homeless community members. The focus of the interventions will be on increasing the longevity of stabilization and evaluating the impact of health outcomes.
Eligible Members	Members experiencing homelessness
Limitations/Restrictions	Requires prior authorization
Responsible Providers	*MyWellCare* application vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare tracks and will report the number of times the application has been downloaded.

Improving Birth Outcomes through Prenatal, Postnatal, and Inter-Pregnancy Care

WellCare will support and educate pregnant Heritage Health members on the importance of prenatal and postpartum care through a variety of value-added services designed to engage expectant mothers early in their pregnancy and providing guidance, information and support. Our Prenatal Care Management Program and other value-added services are aimed at preventing low birth weight rates and decreasing the risk of preterm delivery through face-to-face contact with members and providers, member education, member incentives, and supports. These value-added services (**Figure 5**) are described below.

- Prenatal Care Management Program
- Community Baby Showers
- Stroller/Portable Playpen Program
- Doula Services for Pregnant Youth

Figure 5

PRENATAL CARE MANAGEMENT PROGRAM	
Description	Through our Prenatal Care Management Program, we improve care management of pregnant women by engaging expectant mothers early in their pregnancy and providing guidance, information and support. Through this program, we identify members with potential risk factors (behavioral, social and medical) that may adversely affect their pregnancy outcome. The Prenatal Care Management Program will encourage pregnant women to practice good prenatal care through face-to-face contact with WellCare care managers. We conduct direct mailings of educational materials so that members are directed through each stage of their pregnancy. Members may contact WellCare care managers regarding any questions and concerns. WellCare care managers also advocate for consistent follow-up with a member's provider.
Eligible Members	Pregnant members
Limitations/Restrictions	Based on medical necessity
Responsible Providers	WellCare Care Management
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
COMMUNITY BABY SHOWERS	
Description	WellCare will offer free community baby showers for new and expectant mothers. The showers are open to moms during pregnancy or within six months of birth. These events focus on providing mothers with critical health care information for themselves and their babies, successful parenting techniques, a gift basket, an opportunity to participate in a raffle and refreshments. The community baby showers also connect our members with organizations that can help address social variables that impact a healthy pregnancy, such as appropriate housing, nutrition, medical care and counseling.
Eligible Members	Pregnant members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Member Outreach Team
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

STROLLER/PORTABLE PLAYPEN PROGRAM	
Description	Early and regular prenatal care is the cornerstone in preventing low birth weight rates and decreasing the risk of preterm delivery. WellCare will offer its Stroller/Portable Playpen Program to encourage Heritage Health members to receive the care they need for a healthy pregnancy and baby and to prevent infant mortality. This program will provide a reward for Heritage Health members who attend six prenatal visits and one postpartum visit. For completing these important preventative care services, WellCare will provide a free stroller or a portable playpen, which are conveniently delivered to the member's home.
Eligible Members	Pregnant members
Limitations/Restrictions	One stroller or playard per member per pregnancy
Responsible Providers	WellCare Care Management
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
DOULA SERVICES FOR PREGNANT YOUTH	
Description	Pregnant youth being served by the Nebraska Division of Children & Family Services (DCFS) can be supported through the labor and delivery process with the assistance of a doula. WellCare will provide doula services to these members who live in a group home, maternity group home, or in home placement where there is minimal parental support. The goal of this value-added service is to improve birth outcomes, reduce pre-term births, improve prenatal care, enhance members' understanding of the birth process, and increase role of a doula in the overall labor and delivery plan.
Eligible Members	Pregnant members up to age 21 being served by DCFS
Limitations/Restrictions	Based on medical necessity
Responsible Providers	Doulas
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

Coordinating and Integrating Prevention-focused Physical and Behavioral Health Services

WellCare does not carve out behavioral health services to a vendor and instead uses a strategy of integrating behavioral health care management with medical, social and pharmacy management and directly contracts with behavioral health providers. Co-existing behavioral health needs, chronic medical illness and often significant social challenges occur among our higher-risk cohorts today, and we have designed our Care Management programs and services to be holistic and member-centered, including integrated and streamlined approaches for screening and assessment of physical and behavioral health needs, care planning, and monitoring and ensuring services are provided. In addition to our integrated care management supports, we will provide members with value-added services (**Figure 6**) that seek to further coordinate and integrated physical and behavioral services, including:

- Comprehensive Peer Support Program

- Family Support Specialists
- COBALT Therapeutics
- Foster Care Transition Services

Figure 6

COMPREHENSIVE PEER SUPPORT PROGRAM	
Description	As part of our approach in fostering trusting relationships with enrollees and community based providers, we will work closely with peer and peer supports that have often developed strong, positive relationships with members and their families. Peers have experienced similar conditions and circumstances as members, and have successfully recovered from them. They will provide substantial support, information, education, guidance and coaching for members particularly when it comes to medication. Peers and peer supports will also help members develop and lead their own service plans, including Wellness Recovery Action Plans and help empower members to implement them. They will help members identify triggers that worsen symptoms and develop strategies for dealing with them, including contacting their physician or psychiatrist.
Eligible Members	Members with a behavioral health diagnosis
Limitations/Restrictions	Participation in active case management program
Responsible Providers	Certified Peer Support and Wellness Specialists
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
FAMILY SUPPORT SPECIALISTS	
Description	WellCare will partner with the Nebraska Family Support Network to advocate, mentor, and educate families affected by mental, emotional, or behavioral health issues. Families will receive counseling on the side effects of the condition, depression, anxiety, and behavior modification/coaching.
Eligible Members	Members with a behavioral health diagnosis
Limitations/Restrictions	Participation in active case management program
Responsible Providers	Certified Family Support Specialist
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

COBALT THERAPEUTICS	
Description	WellCare provides free, confidential online cognitive behavioral therapy through the COBALT Therapeutics Program. COBALT is a web-based program that offers a portfolio of behavioral health self-management tools for a variety of conditions. The use of COBALT has been shown effective in engaging members in appropriate self-care by reducing the self-destructive cognitive and behavioral patterns caused by depression, anxiety, insomnia and substance use.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	COBALT online service
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
FOSTER CARE TRANSITION SERVICES	
Description	For youth aging out of foster care, medical and behavioral health needs may continue after they become an adult and they will need to learn to navigate the health care system. Most children have parents or family members to assist them in this process, however this population often needs help and guidance with their overall health care literacy. A key component of WellCare's care management model is the assignment of a care manager to each member in foster care. The care manager is assigned to the transitioning child to provide health education and literary services to understand critical components such as how to access benefits, co-pays, provider network, frequency of visitation, and importance of preventative care. The WellCare care manager will partner with the member's Independence Coordinator assigned through Nebraska's Bridge to Independence (B2I) program to support and supplement their efforts to help the member transition to adulthood.
Eligible Members	Members in foster care, ages 18-20
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Care Management
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

Improving Overall Health and Wellness

WellCare has developed a set of value-added services (**Figure 7**) to reach all Heritage Health members across the state to educate and empower them to access resources designed to improve their overall health and well-being. These value-added prevention focused services seek to address a variety of chronic conditions including diabetes, asthma, cardiovascular related conditions, obesity, and other diseases. These services are aimed at providing incentives and rewards to members by encouraging them to be active and educated consumers of health care services that will improve their long term health and wellness.

- Health Rewards Program
- Hypoallergenic Bedding Allowance
- Weight Watchers
- Over the Counter (OTC) Benefits
- Discount Card
- Tobacco Cessation Programs

Figure 7

HEALTHY REWARDS PROGRAM

Description

WellCare Healthy Rewards Program rewards Members who complete specific preventive health, wellness and engagement milestones with a Healthy Rewards debit or gift card. The Healthy Rewards debit or gift card is credited with dollars upon completion of specific activities and services, which may include the following:

Activities and Services with Incentives for Completion

Population Segment	Focus Area	Activity Criteria
New Members	Initial PCP Visit	Initial PCP Visit within 90 days of enrollment
	Health Risk Assessment	Each quarter, WellCare of Georgia will draw the names of four people and provide them with an IPad.
Children's Health	0-15 months of age	Well child visit per periodicity schedule (six visits)
	3-6 years of age	Child health check-up visit
	7-21 years of age	Adolescent check-up visit
Health Pregnancy	Prenatal Care Visits	Attend ≥ six prenatal visits before the birth of the baby
	Postpartum Care Visit	Attend one post-partum visit 21-56 days after the birth of the baby
	Completion of Both	Completion of prenatal + postpartum visits = total incentive
Diabetes	Diabetes	Complete eye exam (Members with diabetes ages 18-75)
		Complete HgbA1C lab test (Members with diabetes ages 18-75)
Well Woman	Cervical Cancer Screening	Complete office visit for cervical cancer screening (pap smear) (ages 21-64)
	Screening Mammogram	Completion of screening mammogram (ages 40-65)
Adult Health	Annual Adult Health Screening	Complete annual adult screening (wellness visit – Members > 21 years of age)

Eligible Members	All members
Limitations/Restrictions	Members must meet requirements for established healthy behaviors
Responsible Providers	NOVU

Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
HYPOALLERGENIC BEDDING ALLOWANCE	
Description	The burden of asthma is most severe among populations with lower socioeconomic status, those living in low-income neighborhoods and certain racial and ethnic minority groups. To complement our asthma disease management program and our efforts to improve asthma outcomes and reduce clinical disparities among those with asthma, we provide an allowance for hypoallergenic bedding (i.e., bed linens, cushions, mattress protectors and pillow coverings). Providing this benefit for those with an asthma diagnosis helps them reduce their exposures to asthma triggers, which can prevent asthma-related emergency department visits, hospital admissions and missed days of school and work. Members in need of this benefit are identified through utilization management criteria associated with asthma triggers. By effectively managing asthma triggers, we can prevent asthma-related emergency department visits, hospital admissions and missed days of school and work.
Eligible Members	All members with an asthma diagnosis
Limitations/Restrictions	Based on medical necessity
Responsible Providers	Durable medical equipment (DME) providers
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
WEIGHT WATCHERS	
Description	Obesity can be a direct trigger for serious health care issues such as diabetes and heart disease. To address this problem, WellCare offers a weight loss program that provides a free six-month membership to Weight Watchers. The program has been popular in other states where we have offered the service. Members receive the following: ➢ Simple ways to make healthier food choices ➢ A weight loss plan based on the latest nutritional science ➢ This program is offered at no cost for six months ➢ To be successful attend weekly Weight Watchers meetings and reach the goals given to you by your WellCare Health Coach
Eligible Members	Obese members (age 13 and over) identified by WellCare's disease management unit via the completion of Health Risk Screenings (HRS), physician referral, or self-referrals
Limitations/Restrictions	Requires prior authorization
Responsible Providers	Weight Watchers Clubs
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.

Reporting	WellCare will use existing service codes to identify service in administrative data.
OVER-THE-COUNTER (OTC) BENEFITS	
Description	Medicaid members have limited resources with which to purchase needed over-the-counter (OTC) benefits to meet their daily living needs. WellCare will offer a $25.00 head\-of-household monthly OTC medication allowance benefit to our members in order to promote self-directed prevention, maintenance and on-going medical management. Items offered will not only include traditional products (e.g. diapers, pain relievers, vitamins) but will be expanded to also include eyeglass kits, reading glasses, and assistive aid devices such as pill containers or magnifying glasses to improve adherence to medication usage and to avoid errors in taking their medications which could result in hospitalization. Members may order products from our OTC catalog by our toll-free customer service line where they can speak with a representative or place their order using our automated phone service. Members may also log onto our website from a computer or smart phone and place their OTC orders.
Eligible Members	All members (households)
Limitations/Restrictions	Not applicable
Responsible Providers	OTC vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
DISCOUNT CARD	
Description	Members will receive monthly discounts beyond what is available to the general public from pre-selected retailers. This benefit allows members to purchase needed items (e.g. milk, bread, detergent, and over-the counter pharmacy items) at a discount and supports the financial barriers faced by low-income Medicaid eligible.
Eligible Members	All members
Limitations/Restrictions	Members must meet established requirements
Responsible Providers	Discount care vendor
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

Tobacco Cessation Programs	
Description	Smoking is the leading preventable cause of death worldwide, and quitting smoking significantly reduces the risk of dying from tobacco-related diseases such as heart disease and lung cancer. While a great deal of progress has been made in Nebraska, Tobacco Free Nebraska (TFN) reports that the rate of smoking among all adults in 2013 was 18.5 percent, and the rate among youth (grades 9-12) is 11 percent (down from 34 percent in 1993). Nationally, 70 percent of smokers would like to quit smoking, and 50 percent report attempting to quit within the past year. The majority of smokers who try to quit do so without assistance, though only 3 to 6 percent of quit attempts without assistance are successful. For this reason WellCare will supplement TFN's smoking cessation services by providing educational materials, gum, patches, lozenges, and help with obtaining counseling for qualified members
Eligible Members	All members
Limitations/Restrictions	Based on Medical Necessity
Responsible Providers	Durable medical equipment (DME) providers
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

Improving Health Outcomes through Community Engagement

We recognize the power of the social safety net community to help us reach members. Disadvantaged and vulnerable circumstances impact the availability and accessibility of health care and influence lifestyle choices that impact health outcomes. Therefore, we offer the following value-added services (**Figure 8**) to improve health outcomes through ongoing community engagement.

- Welcome Room/Concierge
- Health Fairs
- WellCare Days
- Mini Farmer's Markets
- Health*Connections* Activities

Figure 8

Welcome Room/Concierge	
Description	Provides support for medical and non-medical needs. Includes application assistance, transportation assistance, community support needs.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Community Relations staff
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

HEALTH FAIRS	
Description	WellCare's Community Relations staff will attend and participate in health-focused events to share information, resources and education concerning a variety of health topics such as diabetes management, back-to-school health, the importance of physical activity and general overall health and well-being.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Community Relations staff
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
WELLCARE DAYS	
Description	WellCare will conduct on-site events called *WellCare Days* to promote and educate members on health plan resources and health information. We will conduct *WellCare Days* events in key locations and agencies across the state to conveniently provide members with health education, information and benefit assistance on site. When we host a *WellCare Days* event, our Community Relations staff will set up iPads with health information on asthma and diabetes on which members will be able to interact and gather helpful information.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Community Relations staff
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.
MINI FARMER'S MARKETS	
Description	WellCare will hold Mini Farmer's Markets throughout the state to educate and promote health nutrition. At these events, we make a small display of healthy fruits and vegetables available to members. We will hold up to 10 events annually and plan to continue holding these events in conjunction with community partners. The events promote healthy living information such as good nutrition practices and portion control.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Community Relations staff
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.

Member Access to Service	Benefit will be included in member service plan.
Reporting	WellCare will use existing service codes to identify service in administrative data.

HEALTH*CONNECTIONS* ACTIVITIES	
Description	Through our CommUnity Advocay efforts built from our proprietary Health*Connections* model we partner with community organizations to locate and educate members. In Nebraska, we have already been building these relationships meeting with agencies from across the state and already have such partnership commitments including Together in Omaha which helps people access documents like birth certificates and social security cards or SPEAKOUT in Western and Central Nebraska which helps people apply for various benefits. The beauty of the WellCare model is it benefits WellCare members and the community at large. Through these partnerships, not only will we be able to better reach and educate our members, anyone who accesses services through one of our partner agencies can also benefit from access to our one-of-a-kind CommUnity Assistance Line and Navigator Database. These are the programs we use to connect people in need to social support services – such as housing assistance, food banks or transportation. Our database of programs in Nebraska already contains some 5,000 groups. The primary goal of the Health*Connections* model is to improve the health and vitality of our members and communities by sustaining the social safety net and quantifying its impact on health outcomes. WellCare has identified four complementary program elements to achieve this goal. ➢ **CommUnity Activities**: Community-based health and wellness events leveraging existing programs. ➢ **Health*Connections* Councils**: Community-planning councils focused on quantifying the breadth and scope of the available social safety net and identifying creative and innovative ways to sustain the network together with other community and civic leaders. ➢ **Social Service Utilization Support:** Facilitating member connections to social services and bridging gaps in available community-based programs and services. ➢ **CommUnity Health Investment Program:** Strategic philanthropic granting program to support community-based innovation and to pilot potential social service payment models. In 2014, WellCare expanded the CommUnity Health Investment Program to include nearly 50 individual investment programs in five different states. To support the primary goal identified above using the four complementary strategies, WellCare created the CommUnity Command Center, a comprehensive and inter-related data lake of community-related information across multiple databases that provides our staff ease of access to community supports that other managed care organizations simply do not have. In addition to natural supports, service providers and community stakeholders, information is shared across the health care delivery system, to facilitate a comprehensive, holistic and person-centered approach to care and address issues and concerns as they arise.
Eligible Members	All members
Limitations/Restrictions	Not applicable
Responsible Providers	WellCare Community Relations staff
Notification of Availability	Members will be notified through Member Handbook, website, and WellCare newsletter. Providers will be notified through Provider Manual, website, and onsite education and training.
Member Access to Service	Benefit will be included in member service plan.

IV.E COVERED SERVICES AND BENEFITS

24. Describe the MCO's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the MCO's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established timeframes. *(Page limit 4 pages)*

ENSURING MEMBERS UNDER 21 RECEIVE EPSDT SERVICES

WellCare's comprehensive Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program is designed to connect children and their families with appropriate preventive care and medically necessary treatment and/or services to correct or ameliorate health conditions. Chronic and/or complex physical or behavioral health issues are identified, prevented, managed and treated sooner to ensure that children have the best opportunity to grow into healthy, productive adults. To achieve this goal, our EPSDT program features proactive education, outreach, follow-up, and incentives delivered through a variety of channels targeting members and providers. We have made, and continue to make, significant investments in our EPSDT program and related systems and processes to support nearly 1.6 million members under the age of 21 we serve in our Medicaid markets.

A WellCare Affiliate Example of Excellence

WellCare's affiliate in Georgia is the leader in adolescent well-care visits among all Care Management Organizations in Georgia, exceeding targets.

Our EPSDT program reinforces the principles of the EPSDT health benefit including early assessment at birth and continuing throughout childhood and adolescence. These efforts include:

- Identification, diagnosis and treatment of medical conditions as early as possible,
- Periodic assessment through well-child visits at regular intervals throughout childhood and adolescence
- Screenings for health as well as developmental and behavioral concerns (e.g. health history, developmental and behavioral assessment, physical exam, immunizations, lab tests, nutrition/obesity prevention, oral health, health education, and vision and hearing screenings)
- Effective diagnosis and treatment of health, developmental or social-emotional problems

Our EPSDT program and its formal program description, policy and procedures comply with all Nebraska and federal statutes, regulations, administrative rules, and Medicaid contract requirements governing EPSDT.

OUR APPROACH FOR EPSDT EDUCATION AND OUTREACH

WellCare recognizes the need for multiple varied and innovative strategies to effectively educate and outreach to members and parents and guardians regarding the benefits of EPSDT screening, diagnosis, and treatment services. WellCare will assist members in making responsible decisions about preventive health care and appropriate utilization of health care services. Our EPSDT program features a blend of outreach and informational activities targeted to specific segments of the population, including newly enrolled, age-specific and pregnant. By offering communication through these various avenues, we continually reinforce the importance of EPSDT program and services. Our outreach and informational efforts address the importance of preventive care, periodicity and immunization schedules, information on diagnostic testing, screenings and assessments, how and where to access services, transportation and scheduling assistance, and a statement to members that services are provided without cost.

New Member Education

Member Materials: Our efforts to educate members and parents/guardians about the EPSDT benefit and the importance of following the periodicity preventive health screening schedule begin as soon as members enroll with WellCare. Within 10 calendar days of enrollment, all new members are sent a member packet informing them and their family of the availability and the benefits of EPSDT services. The new member packet contains information on a variety of topics such as outlining the need for a health and screening visit within 90 calendar days of enrollment and within 24 hours of birth. This packet includes a Member Handbook, which has detailed information about pediatric preventive health guidelines from birth through age 21 of available and recommended screening, diagnostic and immunization schedules. The Member Handbook also informs members of their rights to treatment for medically necessary services discovered through preventive health screening visits, including physical and behavioral health conditions.

Member Contact: All new EPSDT-eligible members, including reinstated members, are automatically scheduled for a welcome call within 15 business days of the date we send the welcome packet. The welcome calls with members (or their parents/guardians) will include a health risk screening (HRS) to identify chronic conditions, barriers to accessing care, special needs, pregnancy, or the need for care coordination services. We also determine through claims and encounter information whether the member has seen a Primary Care Provider (PCP) within 90 days of joining WellCare. For those members who have not yet seen their PCP, we mail a letter encouraging them to schedule an appointment for their EPSDT health screening. This direct contact further expands our ability to connect members with their PCPs which improves EPSDT compliance rates.

Targeted and Innovative Member Outreach Strategies: Reaching Members Where They Are

The following are examples of our various EPSDT education campaigns and activities:

- **Ongoing Event-Triggered Outreach:** In accordance with our periodicity letter policy, on a monthly basis WellCare identifies all members having a birthday who may be due for age-appropriate screenings and assessments according to the approved periodicity schedule. We mail state approved, age-specific letters informing members and/or parents/guardians of the recommended screenings and services they may be due for.
- **Proactive Member Telephonic Outreach:** The telephonic outreach program educates members and encourages certain behaviors aimed at improving the rate of preventive care participation of our members. WellCare proactively conducts outbound phone calls for members who have not had an EPSDT visit that corresponds with the appropriate HEDIS measures for recommended visits. The outbound phone call ensures that members and parents and guardians understand the need and importance of seeing their PCP for a well-child check-up including immunizations and lead screenings. Our representatives educate members and parents and guardians and assists with scheduling an appointment with the PCP via a three-way phone call. If transportation is a barrier to care, the representative will also assist in obtaining a ride to and from the appointment for the member. Proactively identifying members and encouraging compliance with EPSDT services has resulted in significant improvements in our corresponding HEDIS measures for these populations.
- **Member Calls to Member Services:** WellCare effectively capitalizes on member-initiated calls to Member Services as an opportunity to remind members about recommended screenings, checkups and immunizations. During the inbound call, the member services representative addresses outstanding care gaps with the member. For children and adolescents, we target adolescent well-care visits, childhood immunizations, lead screening, well-child visits for 0 to 15 months and well-child visits for those 3 to 6 years old. For those members with care gaps, the member services representative provides basic education about the needed preventive service and asks the member if an appointment has been scheduled. If an appointment has not been scheduled, the representative offers to assist the member in scheduling the appointment, and transportation if needed, through a

three-way phone call with the provider's office or transportation broker. Members receive an automated reminder 24 hours beforehand.

- **Pregnancy-Related EPSDT Outreach and Education:** We know the key to healthy children is reaching moms and moms-to-be and supporting their efforts to raise healthy children. WellCare's maternity education program includes a variety of materials including brochures, pamphlets and booklets like *Your Journey through Pregnancy* and *Mommy & Baby Matters*. These explain the importance of newborn screenings in the hospital, well-baby checkups and immunizations. In addition, WellCare staff members provide education, both one-on-one (in person and via telephone) and in group settings at our community prenatal/postpartum education sessions and our community-based Prenatal Baby Showers. Community outreach staff members also provide education on the importance of selecting a pediatrician and scheduling appointments for checkups. Once the baby has been delivered, we use telephonic outreach conducted by our centralized telephonic outreach staff to educate members about the importance of the postpartum follow-up visit and the first well-child checkup. If the member would like assistance scheduling appointments, the outreach specialist facilitates a three-way phone call between the member and her OB provider and/or the baby's pediatrician.
- **Targeted Care Management:** When specific health issues are identified through assessments and screenings, care management is engaged. One such example is our Lead Care Management program for EPSDT-eligible children and their households when there is a positive blood lead test equal to or greater than 10 micrograms per deciliter. The Lead Care Management program supports children, their families, and their providers through education and development of a written care plan that includes all necessary referrals, coordination with public health agencies, environmental lead assessments, and monitoring of non-compliance with follow-up testing and appointments.
- **Community Outreach:** Our Nebraska-based CommUnity Advocates will work with community partners to find innovative community-based programs that use evidence-based practice guidelines to which we refer our members. In addition, our CommUnity Advocates connect with social service agencies to establish a contractual relationship through which we track members referred to services for outcomes reporting. Team members not only create opportunities for member engagement, they also work closely with community partners, providers and stakeholders who are serving our member population to enhance or expand services being offered to the membership base. Among the team's many grassroots efforts are *WellCare Days*, which are outreach initiatives in places where we can most successfully reach members in their communities such as provider offices, school-based health clinics, farmer's markets, health department offices, Women, Infants, and Children (WIC) offices, and other social service agencies. WellCare events, including *WellCare Days*, are designed to educate members on their benefits, PCP home and health screenings (EPSDT, well-baby checkups, prenatal care, etc.).
- **Digital Media and Mobile Technology:** WellCare leverages digital media and mobile technology to reinforce the importance of preventive screenings and immunizations. WellCare's health and wellness member portal provides parents and children with helpful, age-appropriate information about a variety of health topics. Our Kid Zone features child-friendly newsletters, games, comics and coloring books, including information on the importance of dental health. For parents, we offer a library of articles, frequently asked questions and fact sheets related to the various recommended immunizations. In addition, our mobile application for smartphones and mobile devices, "MyWellCare," provides friendly and timely alerts when members are due for wellness services or checkups. The application enables us to send messages to members about important, time relevant items – like reminders about flu shots, upcoming enrollment periods or changes in benefits. WellCare also engages with our Facebook community, which includes members, around topics such as health and social services and support, community engagement, and member and community education and services. WellCare does not share protected health information (PHI) of any kind on social media without expressed permission from the member and/or designated guardian. Member comments on

social media that include PHI are removed by WellCare. In 2016 we expect to launch a Twitter account and a company blog to further these efforts.

- **Reaching Members through Providers:** In addition to outreaching to members directly, WellCare also partners with our providers to conduct member outreach. For example, on a monthly basis, WellCare sends providers a list of WellCare members assigned to the PCP who are not in compliance with the health check periodicity schedule and/or have failed to access initial health check services within 90 days of enrollment based on claims history. The letter encourages the provider to outreach to the members to schedule appointments. We also leverage our provider portal which includes member-level information about specific screenings, immunizations and overdue services. In addition, our Nebraska-based Clinical HEDIS Practice Advisors (CHPAs) deliver education and consultation to providers and provider practice sites on a number of preventive and chronic health management measures including immunizations and well-child/well-care checks. They assist provider offices with barrier analysis and developing strategies to improve compliance within the practice.

WellCare's System for Tracking and Ensuring Delivery of EPSDT Services

WellCare uses data to not only optimize our outreach efforts, but to objectively evaluate program performance capitalizing on best practices and addressing inefficiencies in order to improve member health, well-being and health outcomes. Our comprehensive efforts and systems to ensure delivery of EPSDT services include quarterly and annual analysis of our EPSDT program to identify population-wide trends and opportunities to improve the program overall. Our performance management metrics include a balanced selection of process-related metrics and outcomes metrics as described below.

Outcomes and Process Measures

On a quarterly basis, our Data Analytics and Quality Improvement teams analyze EPSDT-related outcomes and process measures, looking for program performance, trends and opportunities for improvement. As part of this analysis, we evaluate outreach contacts and compliance rates in total as well as by race, region, ethnicity and screening or service. The insights derived are then applied to program enhancements. Measures include, but are not limited to, the number and percentage of members having screens/visits as prescribed by the Recommendations for Preventive Pediatric Health Care Bright Futures Periodicity Schedules; members receiving appropriate immunizations, lead and TB testing; and members receiving diagnostic and treatment services, including referrals. WellCare also tracks process measures to evaluate program activity, including the number and percentage of members mailed periodicity reminder letters, providers mailed a list of members needing health check screening, and members on the provider's monthly membership list.

Medical Records Audit

WellCare conducts annual review of contracted provider office medical records using criteria based on general medical record documentation standards and adherence to preventive care guidelines. The review identifies compliance with medical record review standards and if needed, opportunities for improvement. A random sample of providers is selected each year. The EPSDT component of the audit evaluates provider adherence with EPSDT recommendations within each of the randomly selected medical records. Individual provider corrective action plans are required for providers who are below 80 percent compliance with all elements of the review.

25. Describe the MCO'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 MCO's utilization management strategies. *(Page limit 3 pages)*

REACHING MEMBERS WHERE THEY ARE: WELLCARE'S APPROACH TO TELEHEALTH

WellCare has adopted a telehealth strategy to provide a tangible way to expand access to care for members in areas that have few providers or in instances where a member has difficulty traveling to be seen. Among its many benefits, telehealth increases access to specialty care for patients in rural and frontier areas, decreases travel time and saves money for patients and caretakers.

As we traveled the state building our Nebraska strategy and meeting with stakeholder organizations, we learned that there is a strong appetite for telehealth solutions and a great opportunity for more innovation by managed care organizations in the state to support telehealth initiatives. The Center for Rural Affairs in Lyons, for instance, shared with us a significant need for telehealth innovation that takes these technologies to the next level for the communities they represent and shared with us exciting early opportunities that can be leveraged and supported moving forward, including interesting initiatives in neighboring South Dakota. Whether it's one of the Tribal Clinics we met with that is using telepsychiatry to support their behavioral health patients or one of the state's largest providers of children's services equipping each of its clinic with telehealth capability, it was clear to us that the time is ripe for innovation and expansion of telehealth opportunities for the people of Nebraska.

From our experience with Medicaid managed care programs, we have identified three primary ways we will support, promote and/or facilitate the use of telehealth in Nebraska:

- Develop reimbursement methodologies to make it worthwhile for providers to use existing technologies to conduct telehealth such as reimbursement for the hosting site
- Help support through grant funds the development of new telehealth sites in remote areas where such services don't currently exist
- Provide for the technology to support direct provider to member care using telehealth technologies, such as Cobalt Therapeutics, an online tool for members to access Cognitive Behavioral therapy and self-management tools; or through our relationship with American Well, a telehealth company that provides a network of available providers online 24/7.

Implementing Telehealth throughout Nebraska

WellCare will partner with providers, groups of providers and with the Nebraska Statewide Telehealth Network (NSTN) to extend health care resources to those in need using video technology. NSTN is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, physician offices and rural health clinics. This includes clinical consultation, support groups, education and training and connectivity for administrative meetings among professionals.

Telehealth Reimbursement

As a value-added service, WellCare will reimburse telehealth originating sites for hosting services.

WellCare's telehealth providers will be required to follow all applicable state and federal regulations governing their practice and the services they provide. WellCare will follow all MLTC policies and procedures as defined in 471 NAC 1-006, including site criteria and conditions for payment. Our telehealth sites will be required to conduct telehealth via interactive telecommunication systems and in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Health care facilities that receive reimbursement for

consultations provided by a Medicaid-participating provider will also be required to establish quality-of-care protocols and patient confidentiality guidelines.

- **Equipment Criteria:** Medicaid-covered telehealth services delivered by a health care practitioner must utilize an interactive audio and video telecommunications system that permits real-time communication between the health care practitioner at the distant site and the client at the originating site. Reimbursed telehealth services will not include a telephone conversation, electronic mail message, facsimile transmission between a health care practitioner and a client, a consultation between two health care practitioners and asynchronous "store and forward" technology.
- **Confidentiality and Security Criteria:** WellCare will require that interactive video telecommunications comply with HIPAA patient privacy regulations at the member's location, the consulting provider's location and in the transmission process. All communication must also be on a secure network in compliance with HIPAA encryption and redundancy requirements.
- **Telehealth Reporting:** We will identify and report on all locations of telehealth presentation sites and the number of providers who commit to providing telehealth.
- **Reimbursement:** WellCare will cover medically necessary telehealth services at a rate comparable to an in-person consultation. As part of our value-added set of services, WellCare will also reimburse originating sites for hosting services.
- **Safety Plan:** For each member receiving telehealth behavioral health services, a safety plan will be developed, should it be needed at any time during or after the provision of the telehealth service. This plan will document the actions the member and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth service.
- **Pediatric telehealth behavioral health services:** For each member who is a child who is receiving telehealth behavioral health services, an appropriately trained staff member or employee familiar with the child's treatment plan or familiar with the child will be immediately available in person to the child receiving a telehealth behavioral service in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child's parent or legal guardian. The medical record shall document the waiver.
- **Originating Sites:** Where there are gaps in service locations for originating sites, WellCare will leverage our CommUnity Advocacy team to identify ways to address member access. We will look for opportunities to partner with a local library, community action agency, or other organizations to support HIPAA-compliant telehealth originating site services. As necessary, we will also equip our geographically dispersed Welcome Rooms, which can serve as convenient telehealth originating sites.
- **Telehealth Online:** WellCare's telehealth program in Nebraska will also include web-based consultations to our members. This innovative service will provide members with online (through two-way video technology) physician consultations for clinically appropriate conditions. Members will be able to access through a secure Internet connection or an app on their mobile phone. This service will complement the continuum of options for our members, enhance their access to services and provide alternatives to the emergency department.

Examples of innovate efforts that WellCare has undertaken and will leverage as appropriate include:

- **School-based Health Centers:** WellCare of Georgia provided the funding to equip Appling County Elementary and Appling County High schools with telehealth systems which will allow school nurses to connect injured and sick students and faculty to health care providers at Appling HealthCare System via a video conference
- **Pilot programs:** We are piloting programs in New York, Kentucky and South Carolina that will target reducing hospital readmissions through the use of telemedicine, including leveraging telemedicine platforms to connect case managers and members. In South Carolina, telehealth is being used to engage members after discharge to ensure they are making their follow-up programs and

compliant with their discharge plan.

Member Preference for In-Person or Telehealth Services

Interest and satisfaction in telehealth is increasing as more people become comfortable with the technology. Some even prefer it. WellCare will enable Heritage Health members to make their own decisions about whether telehealth is right for them:

- **Member Education:** We will educate members through multiple avenues of communication. WellCare's provider relations representatives in rural and frontier areas will distribute colorful member-friendly brochures to providers in their regions, so providers can make them available to our members. The brochure will include a toll-free number and the website for members to obtain information about telehealth scheduling and referrals. Additionally, WellCare distributes quarterly newsletters by mail and online. Our newsletters will periodically include information about how members can learn more about using telehealth by asking their doctor or calling Customer Service.
- **Member Informed Consent:** Before an initial telehealth service, WellCare will require that health care practitioners provide the member (or parent/guardian) with written information in the form of the *Nebraska Medicaid Telehealth Patient Consent Form* which must be acknowledged by the member. An information packet will include Health Insurance Portability and Accountability Act (HIPAA) information and the consent form to acknowledge that telemedicine will be used. The consent form will include what alternative options are available, including in-person services, all existing laws and protections (e.g. confidentiality, access to medical records, and dissemination of member identifiable information), whether the telehealth session will be recorded, and the right to be informed who is present during the telehealth session.

TELEMONITORING

Telemonitoring involves easy-to-use equipment to help members track their vital signs at home. Vitals are transmitted automatically to a provider and monitored by a nurse. WellCare has begun discussions with several telemonitoring companies and is currently evaluating platforms and services for telemonitoring. WellCare believes that telemonitoring can be used to prevent hospital admissions and readmissions. At a minimum, WellCare will cover telemonitoring services when the following conditions have been met:

- The member has been hospitalized two or more times in the last twelve (12) months for conditions related to the disease. This provision is not required for infant apnea monitoring
- The member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data
- The originating site has space for all program equipment and full transmission capability
- The provider's record contains data that supports the medical necessity of the service, all transmissions, and subsequent review received from the member, and how the data transmitted from the member is used in the continuous development and implementation of the member's plan of care

As a value-added service, WellCare will also provide telemonitoring services for diabetic members, when clinically appropriate, so they can send daily blood glucose readings to their provider and a diabetic nurse.

Telehealth and Telemonitoring: An Integral Part of our Utilization Management Strategies

We believe these tools can help us reach the goals of our Utilization Management strategies to ensure members get the right levels of care at the right time and aren't forced into higher levels of care simply because the right level isn't available. And to further streamline access, WellCare does not require authorization for referrals to telehealth specialists.

IV.E COVERED SERVICES AND BENEFITS

26. Describe the MCO's experience with an integrated pharmacy benefit in other states and specify the type of plan and enrollment. Provide a preliminary work plan identifying key milestones, tasks, and accountability for implementation of Pharmacy Services as described in the RFP. *(Page limit 3 pages, excluding preliminary work plan)*

PROVIDING INTEGRATED PHARMACY BENEFIT TO MEMBERS

WellCare has more than 20 years of experience serving the pharmacy needs of Medicaid members. ***Annually, we manage more than 200,000 pharmacy prior authorizations across all of our Medicaid plans with nearly 100 percent resolved within 24 hours where required.*** In accordance with the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) requirements, WellCare will provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and will follow the Nebraska Medicaid preferred drug list (PDL). WellCare of Nebraska's Pharmacy Director, who will be a registered pharmacist with a current Nebraska license, will work collaboratively with our corporate pharmacy department and MLTC to coordinate the necessary clinical services and to ensure appropriate pharmacy benefit design, decision-making criteria, and formulary exceptions are followed.

WellCare's Experience with an Integrated Pharmacy Benefit in Other States

WellCare currently provides integrated pharmacy services across eight states. The table below (**Figure 9**) summarizes plan types and enrollment:

Figure 9

WELLCARE INTEGRATED PHARMACY BENEFIT			
Experience			
State	**Plan Type**	**Enrollment**	**Start Year***
Florida	Medicaid (TANF, ABD), CHIP	752,000	1985
Georgia	Medicaid (TANF), CHIP	589,000	2006
Hawaii	Medicaid (TANF, ABD), Behavioral Health	48,000	2009
Illinois	Medicaid (TANF)	173,000	2004
Kentucky	Medicaid (TANF, ABD), CHIP	436,000	2011
New Jersey	Medicaid (TANF, ABD, MLTSS)	60,000	2013
New York	Medicaid (TANF), CHIP	113,000	2002
South Carolina	Medicaid (TANF, ABD)	62,000	2013
**Start Year indicates the first year in which WellCare manages integrated pharmacy benefit.*			

Our approach in each state is tailored to the needs and requirements of our government partners. In 2014, for example, we implemented the State of Florida's Medicaid PDL for our 752,000 Florida Medicaid members.

WellCare's Pharmacy Operations Model

WellCare's experience in pharmacy operations is characterized by our unique hybrid model (**Figure 10**) with a number of critical pharmacy management functions performed in-house by WellCare personnel coupled with the activities of a pharmacy benefits manager (PBM). Under our hybrid model, our corporate pharmacy resources are responsible for prior authorization determinations, appeals, claims testing, Pharmacy and Therapeutics (P&T) Committee, quality improvement, retrospective drug utilization reviews, rebate management, and members and provider communications. Our PBM partner processes the pharmacy claims point-of-sale, contracts and remits the pharmacy network, performs phone, desk, and on-site audits, coordinates transition of care, answers after-hours provider calls, and provides explanations of benefits.

Figure 10

WellCare's Pharmacy Operations Model

WellCare's pharmacy operating model retains critical pharmacy benefit management functions in-house managed by experienced WellCare staff.

WellCare is responsible for:

- Coverage Determination Requests
- Redeterminations & Appeals
- Formulary Development & Management
- Pharmacy &Therapeutics (P&T) Committee
- Pharmacy Quality Oversight Committee
- Retrospective Drug Utilization Reviews
- Rebate Dispute Resolutions
- Provider Escalated Calls

Our PBM is responsible for:

- Pharmacy Claims Processing
- Pharmacy Network Development
- MAC List Management
- Audits
- Transition of Care letters
- After-hours Provider calls
- Explanations of Benefits (EOBs)
- Pharmacy Remittance Advices

Corporate Pharmacy Organization

WellCare's corporate pharmacy organization employs more than 380 associates, including a senior medical director, 40 clinical pharmacists, 195 pharmacy technicians and 154 support staff and management personnel (of whom 25 are pharmacists). Additional licensed medical directors provide support for pharmacy prior authorization requests on an ongoing basis.

PBM Vendor

WellCare chose our PBM vendor based upon their successful partnership with managed Medicaid clients of all ages during the past 20 years. Our PBM vendor currently manages Medicaid members across 27

states, representing more than 12 million covered lives. The PBM's ability to customize their services and programs to meet the unique needs of Medicaid-focused customers' objectives sets them apart in the marketplace. They have a comprehensive clinical focus that is dedicated to monitoring per member per month utilization and prescribing patterns, while implementing innovative programs that address managed Medicaid members. The PBM's managed Medicaid experience has resulted in the creation of a number of customizable tools that help optimize appropriate drug utilization, including:

- Step therapy programs that operate under nationally recognized, evidence-based clinical guidelines
- Online decision support tool to help us view and manage our plan's performance
- Flexible clinical programs designed to improve key HEDIS measures

The State of Nebraska will benefit from our ability to analyze utilization trends and create custom tools to match their unique needs. Heritage Health members will benefit because we will be in a better position to ensure appropriate access to medications in a timely manner. Figure 26.2 describes our hybrid approach to pharmacy operations.

Pharmacy Operations Workflows

Our experience includes recent investments in our pharmacy prior authorization technology and processes, notably in our custom, proprietary, role- and task-based Drug Evaluation Review (DER) Work Flow System, which serves as our prior authorization platform. This fully automated platform allows us to track and process DER requests, including prior authorizations and formulary exceptions, in a timely manner and in accordance with contract requirements. Key features of the DER Work Flow System include:

- Intelligent routing to specialized pharmacy technicians based on the type of medication requested
- Color-coded alerts to notify pharmacy staff of approaching service level deadlines
- Integrated decision tools that are used by administrative and clinical reviewers to evaluate information provided by the requestor, review the patient's prescription history and consult any and all medical documentation accompanying a request

All prior authorization requests are dated and time-stamped to ensure they are resolved within the required 24-hour time frame (unless an exception applies). If an emergency supply of medication is needed while the DER review is pending, we provide the required 72-hour supply of covered outpatient medication drugs, and will continue to do so. Additionally, to ensure members receive their medications in a timely manner over weekends and when providers' offices are closed, WellCare members are eligible for a seven day supply of medications while the review is being conducted, far exceeding the mandated 72-hour supply. For any DER request that is denied, the system generates a Drug Utilization Reviews (DUR) form and automatically transmits it to the prescriber and the pharmacy (if applicable). The DUR includes a clear description of the reason for the denial, any preferred alternatives or additional details, and other information which the member and provider can use to understand the decision.

PRELIMINARY WORK PLAN

See **Attachment 26a_Pharmacy Services Preliminary Work Plan** for a copy of WellCare's preliminary work plan identifying key milestones, tasks, and accountability for implementation of pharmacy services as described in the RFP. Consistent with those requirements, at least 60 calendar days prior to the contract start date, WellCare will submit to MLTC for written approval all policies and procedures related to the provision of the pharmacy benefit, including the formulary, utilization review policies, procedures to ensure compliance with the PDL, clinical and utilization edits, provider requirements, subcontracts, pricing and reimbursement.

Pharmacy Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
1	**Pharmacy**	**195 days**	**Mon 04/04/16**	**Fri 12/30/16**
2	**Formulary Management**	**171 days?**	**Tue 05/03/16**	**Tue 12/27/16**
3	Obtain benefit design	140 days	Mon 06/06/16	Fri 12/16/16
4	Obtain PDL/RDL	140 days	Mon 06/06/16	Fri 12/16/16
5	Decision on transition policy	140 days	Mon 06/06/16	Fri 12/16/16
6	Establish pharmacy network	101 days	Mon 07/04/16	Mon 11/21/16
7	Rebate contracts	101 days	Mon 07/11/16	Mon 11/28/16
8	Website - pharmacy related	116 days	Mon 06/13/16	Mon 11/21/16
9	Provider/Member communications - all forms	57 days	Mon 07/18/16	Tue 10/04/16
10	Create member eligibility files	111 days	Mon 07/25/16	Mon 12/26/16
11	State/Regulatory reporting - pharmacy related	101 days	Mon 07/18/16	Mon 12/05/16
12	Ensure P & P Compliance	120 days	Mon 05/02/16	Fri 10/14/16
13	Create Step Action Table	102 days	Mon 07/25/16	Tue 12/13/16
14	Pharmacy Prior Auth process	101 days	Mon 07/18/16	Mon 12/05/16
15	Drug Utilization Review (DUR) Program	101 days	Mon 07/11/16	Mon 11/28/16
16	Utilization Management Programs	101 days	Mon 07/18/16	Mon 12/05/16
17	Pharmacy Access	102 days	Mon 07/18/16	Tue 12/06/16
18	Reimbursements	101 days	Mon 07/18/16	Mon 12/05/16
19	Pharmacy Encounters Claims Submission	101 days	Mon 07/18/16	Mon 12/05/16
20	DER	110 days	Mon 07/25/16	Fri 12/23/16
21	Appeals	110 days	Mon 07/25/16	Fri 12/23/16
22	DMR process changes	110 days	Mon 07/25/16	Fri 12/23/16
23	**Pharmacy Operations**	**194 days?**	**Mon 04/04/16**	**Thu 12/29/16**
24	Prior Authorizations	100 days	Mon 07/25/16	Fri 12/09/16
25	Training	99 days	Mon 08/15/16	Thu 12/29/16
26	Reports	100 days	Mon 07/18/16	Fri 12/02/16
27	Call Center Location	67 days	Mon 04/18/16	Tue 07/19/16
28	Develop Training	36 days	Fri 07/01/16	Fri 08/19/16
29	Hours of Operations	100 days	Mon 04/04/16	Fri 08/19/16
30	Appeals	128 days	Fri 12/02/16	Wed 06/28/17

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IV.E COVERED SERVICES AND BENEFITS

27. Describe how the MCO will ensure compliance with the Mental Health Parity and Addiction Equity Act, including how the MCO will evaluate and measure its compliance. *(Page limit 3 pages)*

ENSURING COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

WellCare has developed a best-in-class fully integrated approach to comprehensive, coordinated health care that supports physical, behavioral and pharmaceutical services, as well as social services for our members. We fully support the goals of the Mental Health Parity and Addiction Equity Act (MHPAEA), which generally prevents certain health plans that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. In April 2015, the Centers for Medicare & Medicaid Services (CMS) proposed to apply certain provisions of the parity act to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and the Children's Health Insurance Program (CHIP). We understand there were many substantive comments submitted in response to the proposed regulation; therefore, final implementation plans will need to be revised to reflect any changes made in the final regulation. To date, we have executed our current business to support all aspects of the MHPAEA and will continue to work with Nebraska's Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) to ensure continued compliance with the final regulation.

WellCare is currently in the process of reviewing all of our current behavioral health benefits, prior authorization programs and other utilization management policies to identify any changes that will need to be made to ensure continued compliance. We anticipate having that review completed by July 1, 2016. At that time, and after the publication of the final regulation, we will begin implementing any necessary changes. Given our already integrated approach, our analysis has shown that we are already in a good position as it relates to parity requirements and, in some cases, ahead of the curve.

We believe close coordination between MLTC and Heritage Health managed care organizations will be necessary to carefully review the application of Non-Quantitative Treatment Limits (NQTLs) as we compare physical and behavioral health services and their application to other home and community based and intermediate level services. NQTLs are limitations that are not expressed numerically and cannot be translated into quantitative limitations (such as prior authorization or geographic limitations), including medical management standards, standards for provider admission to participate in a network, and conditioning benefits on completion of a course of treatment.

We also look forward to working with the MLTC to ensure that all services provided in order to be in compliance with the MHPAEA are included in the managed care rates as required in both the Proposed Managed Care regulation and the Proposed Mental Health Parity regulation.

EVALUATING AND MEASURING COMPLIANCE

WellCare operates a fully integrated health plan and as such, we are able to review all of our clinical and operational processes through a single regulatory and compliance program. Attention is paid to all government regulations to assure we are compliant. The MHPAEA requirements are thoroughly reviewed and the areas of the health plan affected by the Act are involved in implementing processes and monitoring compliance. The behavioral health leaders of our organization serve as subject matter experts to inform the company on all issues related to the requirements around meeting MHPAEA. Staff members receive training on MHPAEA, and policies and procedures have been developed. Ongoing review of our utilization management program, health plan benefits and claims processing is performed.

To ensure and measure compliance with MHPAEA requirements, WellCare will undertake the activities outlined in the items below.

Implementing Consistent and Equitable Medical Management Techniques

WellCare ensures medical management techniques utilized are deployed in a single operating system/medical management platform within the standards of NCQA. Providers, whether medical or behavioral, make treatment requests through the same process. The medical review, denials and appeals processes are handled essentially the same with consistent timelines and medical necessity review. We conduct inter-rater reliability analysis annually to monitor and ensure consistent application of utilization management guidelines.

Ensuring MHPAEA Compliance for non-State Plan Services

Authorization of value-added services that go beyond the Nebraska State Plan is reviewed to assure MHPAEA compliance. All members, regardless of their treatment needs, have access to value-added services.

Providing Medical Necessity Criteria upon Request

In making medical necessity determinations, WellCare applies written, evidence-based guidelines and review criteria to ensure members receive the right care, at the right time and in the right setting. Guidelines and criteria are vitally important decision support tools which ensure medical necessity decisions are based on sound clinical evidence. They also enable fair, impartial and consistent decision-making. All medical and behavioral health medical necessity criteria are accessible to members and providers upon request. We post links to our criteria on our member and provider websites as well.

Providing Reasons for Denial of PaymentWellCare uses nationally recognized medical necessity criteria as well as nationally recognized and developed evidence best practice clinical care guidelines to determine the medical necessity of services. To ensure that high quality, clinically appropriate services are provided to members in the right place, for the right length of time, *we minimize prior authorization requirements for most outpatient, community-based services for behavioral health and co-morbid conditions.* We manage these services by analyzing our data and identifying outliers.

If, however, a request for service is made that does not meet criteria, a denial could be issued. WellCare takes a proactive approach on educating our providers and members on how to handle claim denials:

- **Provider Explanation of Payments:** Each explanation of payment to a provider informs them of their obligation to dispute or appeal a claim denial and not to balance bill the member
- **Member Notice of Action:** For denials, a notification goes out to the member explaining their appeal rights through State-Fair Hearing should it be necessary

When a denial is made, our staff members offer or recommend an alternative level of care that does meet criteria. When a request is made for services not covered under a medical or behavioral health benefit, we work with the provider or member to find alternative services as needed. If the member is under 21, we consider if the service meets EPSDT requirements as well. For instance, a member of our Florida affiliate had need of partial hospitalization for an eating disorder which was authorized outside of the benefit package because it was determined the best course of action.

As part of our company-wide commitment to quality and service improvement, we use data from our appeals system to evaluate and measure denial and appeal rates. We generate quarterly and annual member appeals reports to help us identify deficiencies or patterns in specific program areas, including utilization management. We will initiate corrective action as needed based on those findings. These reports will be presented to our Quality Assurance and Performance Improvement Committee (QAPIC) on a quarterly basis and include trends in volume and types of appeals, volume of appeal levels, volume

of appeals over-turned and results for overturned appeals. This analysis will allow us to compare appeals across physical and behavioral health services. As part of our subcontractor oversight process, all appeal data from our delegated subcontractors will be incorporated into the reports presented to the QAPIC.

Providing for Out-of-Network Coverage through a Balanced Approach

WellCare applies out of network criteria the same for medical and behavioral out-of-network services. In general, WellCare will approve out-of-network services for members when an in-network provider is not available, the service needed is not available or the member is experiencing a crisis outside of the network area. WellCare establishes relationships with non-participating providers through a single case agreement (SCA) on a case-by-case basis to address gaps or barriers to care to ensure access standards are met. A SCA allows a member's health care needs to be met within geographic access and appointment availability standards when access to a particular type of provider, including behavioral health providers, is not available through our contracted network.

While we have well-developed processes for providing out-of-network services when necessary, WellCare will conduct comprehensive ongoing monitoring and development of our physical and behavioral health network of providers. This ongoing development allows us to maintain and exceed Heritage Health members' satisfaction rates, Nebraska Medicaid access to care standards, and comply with MLTC contract requirements. To do this, we will review multiple data sources, including quarterly GeoAccess analyses, appointment availability audits, member grievance information, closed panel reports and non-participating provider paid claims. If a network inadequacy or gap is discovered, our Network Development team creates a plan to close the gap. Particularly in rural and frontier areas of Nebraska that lack behavioral health providers, WellCare will provide telehealth services as one of several strategies to improve access. WellCare will enable Heritage Health members to make their own decisions about whether telehealth is right for them through member education strategies and use of the *Nebraska Medicaid Telehealth Patient Consent Form.*

IV.F MEMBER SERVICES AND EDUCATION

28. 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 on-line 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 pages)

WELLCARE'S MEMBER-FIRST PHILOSOPHY IN ACTON: MEMBER SERVICES OVERVIEW

Building long-term relationships with members is the essence of our successful approach to managed care. We understand that these relationships are built on the trust that comes from open, helpful and timely communication with members. This is particularly important when members are transitioning from fee-for-service or other health care delivery systems. To that end, we guide members through this process with care and compassion as we endeavor to improve their health and quality of life.

WellCare's experience in guiding members with a diverse set of needs is broad and includes expertise in serving people with complex needs including aged, blind and disabled, those dually eligible for Medicare and Medicaid, those in home and community based waivers or receiving long term supports and services, and individuals with an array of other special needs. ***Our robust member services operation serviced more than 9 million calls in 2014 across our programs.***

We use a multi-modal approach toward member services allowing us to meet our members where they are and in their preferred mode of communication whether telephonically, by mail, in person, in a welcome room, during member outreach, through social media, our website, our mobile application, email, or instant messaging.

- **Contact Center**: We offer multi-modal contact options to our members. In addition to live agent telephonic interaction, members may contact us by email, chat and social media and request many services using natural language through our enhanced speech recognition call system.
- **In Person:** Our welcome rooms will be located strategically throughout the state to offer members opportunities to meet with a WellCare associate for in-person assistance.
- **Electronic**: Our member website contains a wide array of resources and tools, including the member handbook and the find-a-provider tool. Our members are educated about the availability of our website as part of our initial welcome packet and call and are offered materials in hard copy should they desire them. Our mobile application is also available to members with Apple or Android devices.

BRINGING OUR EXPERTISE TO NEBRASKA: DEPLOYING AN INTEGRATED CONTACT CENTER

WellCare will operate an integrated member services contact center to respond to the needs of Heritage Health members whether for physical, behavioral, pharmacy or social supports. Our one-stop-shop approach is intended to give members seamless access to the services they need in one place and includes access to our robust social safety net referral system. Associates working on our dedicated toll-free member services line will be be specifically equipped with local knowledge of the community to adeptly respond to the needs of our Nebraska members.

Our contact center will be staffed Monday through Friday from 8:00 a.m. – 5:00 p.m. Central Time except on state holidays. Our associates will be specifically trained on all aspects of the Heritage Health plan. Our contact center will be operated based on established and documented policies and procedures including staffing, training, hours of operation, access and response standards, warm transfers, care management referrals, call escalation, data entry, reporting, performance and call quality monitoring. Mapping search engines are available to contact center associates as tools to recommend providers and assist with member transportation. The Nebraska-dedicated toll-free number and hours of availability will be printed in the member handbook and on each member ID card, as well as listed on our website.

Successful Member Engagement

WellCare measured a member satisfaction rate of 90 percent across our nine Medicaid states.

A measure of our success in delivering exceptional customer service is demonstrated by our member satisfaction of 90 percent, across our nine Medicaid states January through July 2015. We will combine this expertise with our understanding of local issues as we implement our Nebraska-specific member services program.

Training of Customer Service Staff: Initial and Ongoing

WellCare will use our well-established training policies, processes and procedures to support our customer service contact center prepare for serving Nebraska members. These trainings will be customized for the unique needs and requirements of Nebraska. Our processes include a train-the-trainer methodology, training supervisors first and then contact center staff, and a detailed contact center training plan with documented completion. WellCare has developed, refined and consistently utlized this curriculum to effectively prepare thousands of member services associates, including those servicing markets and assisting beneficiaries new to managed care.

New Hire Training Program

Our member services associates undergo a comprehensive training and testing regimen prior to being placed on the inbound phone queue. Initial training consists of four-weeks of instructor-led, classroom-based training. Associates will be specifically trained on all aspects of the Heritage Health plan and will be able to service all members regardless of their needs – physical, behavioral, pharmacy or social supports. Our training curriculum consists of 37 courses that include, among other topics:

- A comprehensive overview on Medicaid and the Heritage Health plan including state geography, culture and correct pronunciation of cities, towns and surnames
- Health plan operations including special populations, member rights and responsibilities, advance directives, grievances and appeals handling, reporting fraud and abuse, care management, prior authorizations, identifying and handling quality of care and service concerns, PCP assignment, early and periodic screening, diagnostic and treatment (EPSDT) services, our provider network, and pharmacy services to name a few
- Needs of members receiving Long-Term Supports and Services (LTSS) including coordination with Nebraska Area Agencies on Aging and other care coordination entities for the LTSS population
- Member experience including building member connections and telephone etiquette
- Health crises, including but not limited to suicidal callers
- Cultural competency and sensitivity training
- Social determinant's impact on members' health and wellness and connecting members with community resources through our CommUnity Liasons and CommUnity Assistance Line
- Processes for speaking with caregivers and guardians while complying with privacy laws

- Use of our CAREConnects system, how to assess caller needs, determine urgency (and handle the calls accordingly), the processes for call routing (including routing to care managers), call escalation, accessing program information (e.g. benefits) to effectively and efficiently respond to inquiries, links to Health Effectiveness Data and Information Set (HEDIS) care gaps and care management programs

Following completion of the classroom-based training, the prospective associate must demonstrate proficiency by successfully completing a skills and knowledge test. Those who achieve 85 percent or better on the proficiency test, are shifted to training in a transition setting. In the transition training environment, the prospective associate is placed on the phone while he or she is closely monitored by supervisors who listen in on calls through our telephone monitoring system. While in transition training, the prospective associate is evaluated on a daily basis on his or her response time, telephone etiquette, accuracy, and knowledge of our operations. Upon successful completion of the transition training period, the associate is certified by the supervisor. The associate is then promoted to a regular phone queue.

Ongoing Training Program

Our member services associates are engaged in training activities on a regular basis including programmatic changes, prior authorization modifications and identifying and handling quality of care or service concerns. In addition, associates are required to complete certain training annually. These training topics include cultural competency; fraud, waste and abuse; Health Insurance Portability and Accountability Act (HIPAA), and advance directives. Ongoing role-based training is provided in a variety of formats including instructor-led training, team meeting-based training, and rigorous web-based training with auto triggering reminders. Additionally associates receive weekly one-on-one coaching from their supervisors based on the results of call-monitoring, and review of member complaints and grievances. Our advanced speech analytics system automatically alerts a supervisor in real time to join a call to facilitate ongoing training and call resolution.

ROUTING CALLS TO APPROPRIATE PERSONS

Best-in-Class Solution

Our advanced speech analytics can flag key words and alert a supervisor in real time to join a call as needed.

CAREChannels, our telephone and communication platform, is designed to enhance the member experience. Our enhanced speech recognition automated call distribution system effectively answers, routes, tracks and reports calls and inquiries. This solution allows members to gain access to the information they seek or perform routine transactions by speaking naturally. Many of the informational and transactional services available on our website are accessible telephonically. Members may speak naturally to request an ID card and even order over-the-counter supplies. The system provides callers with clear, easy-to-follow instructions on what to do in case of an emergency. Callers are also informed calls may be monitored for quality purposes.

WellCare will use a single member services line for all members, eliminating the need for members to call separate numbers. Our enhanced speech recognition interactive voice response system allows members to speak naturally about their needs and be routed accordingly. During normal business hours, members will be connected to a live agent upon choosing that option. Our member services associates handle all call types, including behavioral health and pharmacy. Should a member need to be transferred to another area within the company, a warm transfer occurs. The associate provides the person picking up the call a brief summary of the member's concern and introduces the member before exiting the call. Members may access the behavioral health crisis line by speaking naturally. Our crisis line is staffed 24 hours a day, 7 days a week with licensed mental health clinicians who are trained to provide telephonic crisis intervention services and have the ability to direct crisis care needs using a comprehensive database of community emergency crisis services. Calls are also tracked to ensure outreach by the crisis team should the caller be disconnected or hang up. Our telephone platform also allows member services

associates to warm transfer members to outside entities such as provider offices or state agencies to facilitate the provision of high quality member service.

Care Manager Transfer and Call Escalation

Members who have an assigned care manager have direct access to their care manager during business hours. Our contact center will also have specific policies and procedures regarding transfer of member calls to a care manager during normal business hours. If a call transfer is not possible, we will ensure that a care manager is notified and returns the call within 30 minutes.

In the event of urgent yet non-life threatening matters, the associate will assess the situation and attempt to resolve the matter using available CAREConnects' logic and support tools. For example, if a member is having difficulty obtaining medication or is out of medication, the associate contacts the provider, pharmacy or any other necessary source in order to assist the member in obtaining his or her medications in a timely manner. Once the associate has exhausted all options to assist, the call is transferred to the pharmacy escalation team. This team has additional tools and resources at its disposal including the ability to override certain denials. Documented protocols also exist for urgent and emergent matters including warm transfer to the member's local area 911 services or other crisis and emergency services.

Member services associates are also supported by an "escalation team" comprised of highly-experienced, proficient staff members that handle a variety of complex issues. To proactively intervene before issues are escalated as well as reduce hold-times and transfers, our real-time speech analytics system automatically flags a supervisor to join a call when specific key words are said. This sytem is also used retrospectively for trending and coaching.

24-Hour Nurse Line

Members are able to access our nurse line at any time through our dedicated toll-free member services line. Our 24-hour nurse line team use a nationally recognized triage decision-making tool to assist the member in deciding whether to see their doctor, go to an urgent care center, or seek immediate emergency care. Nurses who answer the nurse line are able to assist the member in making an appointment with their PCP when appropriate as well as locating the closest urgent care center. Our nurse line plays a pivotal role in our program by directing members to the most appropriate site for care and, in return, lowering the cost of care. Nurse line staff include Spanish-speaking nurses, and interpreter services are available for other languages. WellCare will submit our protocols for the nurse line to the MLTC for approval.

MAKING INFORMATION AVAILABLE TO CUSTOMER SERVICE STAFF

Our call management system, CAREConnects, is the proprietary agent desktop solution used by member services. It is built around telephone systems, web capabilities and self-service solutions. CAREConnects efficiently guides member services associates through on-line scripting, workflows, and actions based on the callers' individual needs. ***CAREConnects improves the quality of call handling, ensures consistency across member services associates, facilitates first-call resolution, and allows us to identify and meet members' unmet needs.*** It also helps us identify training needs and increases the effectiveness of training and quality of newly hired member services associates more expeditiously. Analytics and reporting features allow us to identify repeat callers and the reasons for their calls, training opportunities and opportunities for continuous quality improvement. To supplement CAREConnects, we use an extensive on-line library, searchable by key words and inquiry type, available to member services associates.

HANDLING CALLS FROM OUR HEARING IMPAIRED AND NON-ENGLISH SPEAKING MEMBERS

WellCare's member services is available for all callers. Members whose primary language is Spanish are able to easily and directly access our Spanish auto-attendant and Spanish-speaking member services associates. In addition to hiring a diverse staff, we also partner with Voiance Language Services (VLS) to provide oral interpretation services for members with limited English proficiency.

VLS offers interpretation in more than 200 distinct languages and dialects. VLS employee interpreters undergo in-depth screening interviews, qualification assessments, and receive more than 120 hours of classroom training. All VLS language interpreters are based in the United States and are familiar with the vernacular used by our members. When a translation need is identified our member services associates place the caller on hold, contact VLS, secure the appropriate translator, bring the member back on the call, and speak to the translator as if they were the member. ***In 2014, our average connection time to an interpreter was less than 20 seconds.***

Best-in-Class: Language Services

In 2014, almost 7,000 orders for translation services were filled with an average connection time to an interpreter of less than 20 seconds.

In addition to servicing members with limited English proficiency, we also care for members with hearing impairments using TDD or relay services. ***For example, our Florida Medicaid plan annually handles more than 600 TDD/relay calls with an average speed of answer of less than 20 seconds.***

To address members's social service needs, we also use our proprietary CommUnity Assistance Line, which is free and available to anyone, to connect members to social services in their area. The line is staffed by 36 CommUnity Liaisons, two of whom are hearing-impaired. These two peer-support specialists use video relay and video chat to help those who are also deaf or hard-of-hearing to find and access the social services they need to help them mitigate barriers to a healthier life.

Monitoring and Ensuring Quality and Accuracy

Our approach to quality monitoring is extensive and supported through a dedicated, specialized quality assurance team. Continuous evaluation occurs through our quality oversight program which includes call monitoring of at least eight calls per month per associate, real-time audits, and random sampling audits. Supervisors monitor results of call monitoring for accuracy of response and telephone etiquette, secret shopper calls, and random sample audits to learn about individual associate strengths and weaknesses and to identify where coaching is necessary. These efforts are supplemented with real-time listening sessions where supervisors observe the call unobtrusively. Post-call member satisfaction surveys assess the member's experience. The results are analyzed for individual and group opportunities for improvement. All calls are recorded and stored for 10 years.

Monitoring and Ensuring Adherence to Performance Standards

The heart of the contact center operation is our Command Center, located in our headquarters in Tampa, Florida. It is the control center for all member services functions and performance. The Command Center provides real-time monitoring of service levels of more than 200 different skills and call types and coordinates action to achieve service level targets. The Command Center features numerous screens that display data and trends including calls in each queue, length of time callers have been waiting to speak to a member services associate and number of member services associates available to assist callers. The Command Center operation also allows us to quickly adjust to call volumes or emergency situations so members can easily and quickly get resolutions to their concerns or questions.

Our Command Center allows us to measure real time number of calls in queue, hold time, total number of calls, average number of calls, average hours of use and average calls handled per day, week, month, average hours of use per day, busiest times and days by numbers of call.

Our contact center metrics will comply with Heritage Health contact center performance standards including 90 percent of calls answered within 30 seconds and an abandonment rate of not more than 5 percent. All voice mails will be returned no later than the next business day. ***We routinely meet or exceed contact center standards across multiple states as evidenced by our Florida plan which handled over one million calls in 2014, answering 90 percent within 30 seconds with a two percent abandoned rate.*** See **Figure 1** for a sample of member services performance monitoring. We have the capability to analyze call resolution based on language, service level, call type, average speed of answer, average talk time, average hold time, and first call resolution, among others.

Figure 1

MEMBER
Sample Performance Monitoring/3rd Quarter 2014

	Avg. Speed of Answer		Abandonment Rate %		Service Level		Avg. Hold Time	
	Target	Measure	Target	Measure	Target	Measure	Target	Measure
FL	<30	15	<5%	2%	90%	90%	<3 min	00:00:42
GA		20		4%	80%	82%		00:00:33
HI		13		2%	80%	89%		00:02:10
IL		25		4%	80%	85%		00:01:57
KY		12		4%	80%	89%		00:00:52
MO		7		2%	90%	97%		00:00:25
NJ		9		3%	90%	92%		00:01:10
NY		12		2%	80%	94%		00:01:10
SC		14		2%	80%	89%		00:00:29
TOTAL		15		3%		88%		00:00:50

Interactions With Other Organizations

Our phone system supports a warm transfer to any outside entity to facilitate high quality customer service. We routinely warm transfer members to enrollment brokers, state offices, behavioral health crisis lines, provider offices, the Ombudsman, the Department of Health and Human Services fraud and abuse hotline, home and community based services (HCBS) waiver and other case management programs. Our member services associates have the ability to warm transfer calls to MLTC, other MCOs, programs and agencies as appropriate.

Members in need of social services such as housing assistance, a homeless shelter or WIC are connected with our CommUnity Assistance Line where our CommUnity Liaisons help members, their families and the community-at-large find and access community-based programs and services. We maintain an online library of these organizations for our agents to reference in CAREConnects.

After Hours Procedures

We fully understand that our members need access to us 24 hours a day and offer an array of tools that allow members, providers, and partners to obtain access to care, information, and communicate with us 24/7 including:

- Enhanced speech recognition call distribution system through our dedicated toll-free number
- Messaging to advise callers with an emergency to hang-up and dial 911
- Access to the 24-hour nurse line and behavioral health crisis line
- Website and mobile application with self service functions and real-time directory lookup
- Submission of questions and requests via our website and email
- Pharmacy benefits manager (PBM) after-hours service for provider-related issues
- A voice mail box with adequate capacity and messages responded to within one business day

IV.F MEMBER SERVICES AND EDUCATION

29. Describe the informational materials the MCO proposes to send to new members. *(Page limit 2 pages)*

WELCOMING NEW MEMBERS TO THE WELLCARE FAMILY: AN OVERVIEW OF MATERIALS

WellCare will build on our more than 20 years of experience and best practices serving Medicaid and Medicare members to develop effective tools to welcome our new Heritage Health members. Our focus is on empowering members through using robust and compliant information to ensure they have what they need to engage in their own health care and can access the many avenues of support available to them. All new member material for Heritage Health will be provided in a manner and format that is easily understood and will be submitted to MLTC for review and approval a minimum of 45 calendar days prior to contract start date and ongoing.

Identification Card

WellCare has well-established processes and partnerships for the successful and compliant production and distribution of member identification (ID) cards. The member ID card we issue will display the member's name, Medicaid identification number, PCP name and telephone number including after-hours number if different, MCO name and address, member services toll-free number, enrollment broker toll-free number, emergency instructions, and the Nebraska specific website address. Pharmacy electronic routing information will also be on the card. The member ID card will be mailed within ten calendar days of receiving notification of enrollment from MLTC. The letter accompanying the member ID card will explain the purpose of the card and how to use it with the MLTC-issued card, include a reminder to present the card to the member's provider for any health service and a reminder to contact the PCP for all of the non-emergency health care needs. See **Figure 2** for a sample member ID card.

Figure 2

Welcome Packet

New member materials are automatically initiated as enrollment transactions are processed. Our fulfillment and correspondence application generates correspondence and delivers it to print vendors at least daily. When appropriate, individual correspondence can be generated on demand. Each new member packet is given a unique tracking number and is traced throughout the delivery process until confirmation of posting to the portal or acceptance and pick up by the postal service. This unique tracking number also allows us to monitor and act on returned or undelivered correspondence and ensures that end-to-end reconciliation with each enrollment transaction is completed. WellCare can deliver member enrollment materials to alternative individuals when needed, including the ability to automatically send materials for children in foster care directly to the case worker.

In 2014, we successfully fulfilled more than 18 million identification cards, welcome packets and member correspondence.

Using these system capabilities, we are confident in meeting our commitment to ensure member materials are sent within ten calendar days of our receipt of an enrollment file. Member materials are also available

on our member website and secure portal. In developing our welcome packet, our focus is on empowering our members to access services and quickly identifying those members with the greatest health care needs.

Our Heritage Health plan welcome packet will include:

- Welcome letter
- Instructions on accessing the member handbook and provider directory. These instructions will include their availability on the member website and that printed copies may be requested by calling member services
- Website quick guide which will identify materials found on the member website and the availability of printed copies of website material by calling member services
- Member rights and responsibilities
- Availability of member material in alternate formats or communication modes by calling member services
- Information on the appropriate use of the emergency department
- Healthy rewards program brochure, a program that rewards members who complete specific preventive health, EPSDT, wellness, and engagement milestones
- Health risk screening form and instructions for online completion

We may also include other tools in the initial welcome packet or in subsequent member communications such as prenatal care materials, and important phone numbers including nurse line and the CommUnity Assistance line. Members will be directed to call our member services' toll-free line to obtain written material, receive assistance with the member website, or to receive assistance on any other matter. All material included in the welcome packet will be made available on the member website.

Welcome Letter

The welcome letter contains a description of our plan and an ID card reminder, which should already have been received. It advises the member to check the PCP listed on the card to ensure the PCP is the one they have been seeing or is otherwise satisfactory. It instructs the member to consult the online provider directory (available hard copy upon request) and call member services to make a change if he or she prefers another provider. Members may request a PCP change whenever, and as often, as they wish.

The welcome letter also offers a brief overview of how to access health care benefits, including information on our 24-hour toll-free nurse line. It emphasizes the importance of completing the health risk screening and returning it in the enclosed self-addressed, stamped envelope. It will also provide information about options to complete it either telephonically or on the secure member portal. The letter asks members to contact member services with any questions.

Provider Directory

In addition to our web based tools, our hard copy provider directory is available when requested for members, potential members, and the enrollment broker. The hard copy directory for members is updated a minimum of monthly and includes PCPs, specialty physicians, urgent care clinics, federally qualified health clinics (FQHCs), rural health clinics (RHCs), laboratories, radiology providers, behavioral health providers, hospitals, ancillary providers, allied providers and pharmacies participating in the plan. Information includes telephone numbers, service site addresses, board certification status and languages spoken. PCPs, specialists, and other providers not accepting new patients will be identified. Provider hours including the identification of providers with non-traditional hours (before 8:00 a.m., after 5:00 p.m., or any weekend hours) are included.

IV.F MEMBER SERVICES AND EDUCATION

30. Describe the approach the MCO will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the MCO will ensure that materials are at the appropriate reading level. *(Page limit 2 pages)*

MEETING MEMBERS WHERE THEY ARE: OUR APPROACH TO EASILY UNDERSTOOD MATERIALS

Using our WellCare in-house experts, we provide educationally and culturally appropriate member material to more than 2.4 million Medicaid members. Our populations include members from such diverse states as Hawaii, Georgia, New York and Florida. It also includes individuals with a diverse set of needs such as families and pregnant women, youth in or transitioning from Foster Care, those who are aged, blind and disabled and those receiving long-term supports and services.

We use the Centers for Medicare and Medicaid Services (CMS) health literacy toolkit as our guideline when preparing written member material and consult with health literacy experts, as appropriate. In addition, we will consult with our Member Advisory Committee to ensure our materials are culturally competent, understandable and fully accessible, and address our members' health education and literacy needs. Our Member Advisory Committee reviews our outreach materials and processes, including our member handbook, website, member portal, newsletters, social media and other communication tools. We will modify material based on their input. Our Missouri affiliate, for example, recently modified its member handbook based on Member Advisory Committee feedback to add visual highlights and change readability flow. WellCare will comply with all requirements of Section IV.F of this Request for Proposal (RFP) related to member materials, including their distribution to new members within 10 calendar days of enrollment. At a minimum, member material will be in a 12-point font with the exception of the ID card or as otherwise approved by MLTC.

ALTERNATE FORMATS AND LANGUAGES

WellCare makes all required written materials available to our members in alternative formats and in a manner that takes into consideration the member's special needs, including the needs of the visually or hearing impaired, blind, deaf, aged or those with limited reading proficiency. We notify our members that health and benefits information is available in alternative formats, and we provide instructions for accessing them in these alternative formats through the member handbook, member website, outreach activities and during welcome calls when a need is identified. Alternative formats include but are not limited to 508 compliance, Braille, large font letters, CD and verbal explanations of written materials.

All written materials will be provided in English and Spanish and will be reviewed and approved by MLTC. We will prepare materials in any other languages spoken by five percent or more of the enrolled populations, and we will prepare materials in other languages that do not reach the five percent threshold when directed by MLTC or requested by members.

WellCare will proactively use the language spoken data supplied through the state's 834 enrollment file to fulfill new member enrollment material in alternative languages. This indicator is stored in the member record and is referenced and used for member correspondence and communications. For example, members enrolling with a language indicator of Spanish will be sent new member materials in Spanish. Members may also change or update their language preference and subsequent material will be delivered in that language, if available. In addition to new member materials, subsequent correspondence will be fulfilled in Spanish or other required language preferences.

Oral Interpretation Services

WellCare will provide free on-site sign language and oral interpreters for members with hearing impairment or Limited English Proficiency (LEP). Through effective partnerships with interpreters, our

Florida Medicaid plan fulfilled almost 3,000 requests for onsite sign language and LEP/oral interpreters in 2014. These interpreter requests were most typically made for medical (PCP, specialist, hospital), behavioral health, ancillary (dental, vision, hearing), and therapy (physical, occupational, and/or speech) visits.

WellCare partners with Voiance Language Services to provide oral interpretation services in more than 200 different languages for members with limited English proficiency. Onsite sign language interpretation is provided to our members by Interpretek, a national provider of in-person sign language interpreters, as well as video remote interpreting (VRI), which allows interpreters to serve individuals wherever an internet connection exists. Interpretek has Registry of Interpreters for the Deaf (RID) Super Site status, meaning that it meets the needs of the interpreting community on an elevated level. Interpretek will have a Nebraska-specific link on its website, enabling members to request an interpreter online. Members who are deaf or hearing impaired will also be able to access sign language interpreters by calling member services via a telecommunication device for the deaf (TDD) or relay services or through their case managers.

Onsite translation services for members with limited English proficiency are provided through Translation Station. Established in 1998, Translation Station offers translation services in more than 130 languages and is a member of the American Translators Association. Members, providers, and associates will be trained on the availability of translation services – both onsite and telephonic – including how to access the services for members with interpreter needs. Members and providers will be instructed to contact member services to request interpreters, both sign and alternative language. Those in need of onsite translation services will be encouraged to call member services at least three business days prior to the appointment for us to coordinate services. However, urgent requests are filled within 24 hours.

All multi-page written member materials, including the member handbook, will contain information on the process to obtain real-time oral interpretation services in any language and translated written information at no expense by contacting member services. Additionally, all written materials will include a tagline in prevalent languages instructing the member to call member services for materials in other languages.

We will notify our members and potential members that oral interpretation services and translated written information is available at no expense through the member handbook, member website, outreach activities, welcome call, and during any other contact when a need is identified.

Appropriate Reading Level

Member materials are prepared in a style and reading level that accommodates the reading skills of our members. Writing will be no higher than a 6th grade level, as determined by the Flesch-Kincaid Readability Test. Appropriate documentation is maintained and available should MLTC ask WellCare to submit evidence of compliance.

Assisting Members with Special Needs

For our members with special health care needs, the care manager and PCP will work with the member and the family/caregiver to ensure an understanding of the member material and resources available to them. Education material is reviewed verbally and rephrased as appropriate with consideration for health disparities and literacy. Translation, interpreter services and on-site sign language services are always available to facilitate this process. We will also design strategies to meet the needs of our members including those who may be illiterate or require translation services. Examples include such tactics as developing materials with descriptive pictures and less focus on words; facilitating public meetings where information is presented in an oral format; and reading member materials to members.

IV.F MEMBER SERVICES AND EDUCATION

31. Provide an overview of the MCO's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members. *(Page limit 6 page excluding attachments)*

REACHING MEMBERS WHERE THEY ARE: AN OVERVIEW OF OUR MEMBER WEBSITE

Our Nebraska website will be an important communication tool to inform, educate and communicate with members about the Heritage Health plan and WellCare. It will also be an avenue through which we promote health, wellness and service to our members. ***Our single integrated website, which was developed and is continuously enhanced based on feedback from members and caregivers, supports members across the spectrum of care, whether physical, behavioral, pharmacy or social services.*** Our website follows all written marketing guidelines included in Section IV.G and is HIPAA-compliant. All written content found on the member website will be submitted to MLTC for review and approval in advance of its intended posting. Our member portal is interactive and accessible using mobile devices. It also allows member to submit questions and comments electronically to WellCare and receive responses.

Website Reach: By the Numbers

Our Medicaid home pages received about 396,000 visits in October 2015 alone.

Our website meets applicable accessibility requirements, specifically including Section 508 Compliance and support of both English and Spanish languages. Our members may use any browser to access our website and no special interfaces are required. Our website is accessible via mobile devices. It is also compliant with applicable privacy and security requirements when providing or receiving any protected member information, including but not limited to member eligibility or member identification information. Our website is built to recognize location, so a member coming to the Wellcare.com URL will be directed to the Nebraska homepage automatically once the page is live. See **Figure 3** for a screenshot of our draft member website home page for Nebraska.

Figure 3

We recently made a major investment in a best-in-class website to enhance our member's ability to communicate with us. ***The redesign of our website was based on independent research and investigation which included direct feedback from more than 200 prospective members, 800 current members, and 750 providers in addition to competitive analysis reviews and reviews of state and industry sites likely to be accessed by our members and providers***. See **Figure 4** for a detailed description of our member website and secure member portal.

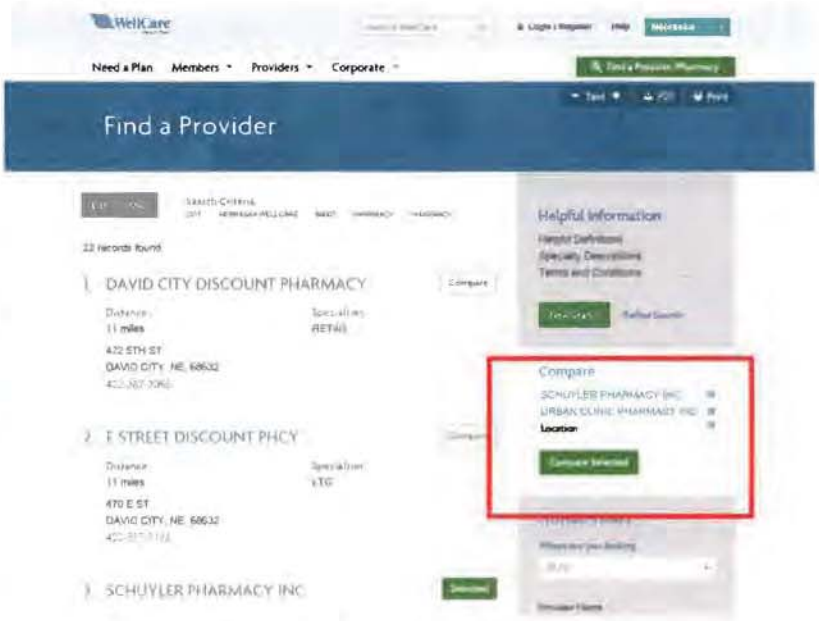
Figure 4

MEMBER WEBSITE CONTENT	
Our website for the general public allows existing members and the general public to access general information without any login credentials. The core web content will include:	
Contact Us	➢ Important phone numbers and addresses including toll free customer service number prominently displayed and telecommunications device for the deaf (TDD) number ➢ Questions/comments ➢ Alternative communication methods with members through things like electronic question submission
Searchable Member Handbook	➢ Member Services Line and 24-hour Nurse Call Line ➢ Pharmacy preferred drug list ➢ Covered services ➢ Service authorization requirements ➢ After-hours and emergency services ➢ Member protections, rights and responsibilities ➢ Grievances and appeals ➢ Cost sharing ➢ Preventive health ➢ Requesting out-of-network services ➢ Health risk screenings ➢ Quality improvement and member satisfaction ➢ Advance directives ➢ Changing MCOs ➢ Reporting suspected abuse and neglect ➢ Ombudsman information ➢ Accessing benefits not paid for by WellCare ➢ How to select or change a PCP
Searchable Provider Directory	➢ Find-A-Provider tool is refreshed daily with current information on network providers that include: ▪ Primary care ▪ Specialists ▪ Urgent care clinics ▪ Federally Qualified Health Clinics and Rural Health Clinics ▪ Laboratories ▪ Radiology providers ▪ Behavioral health providers ▪ Hospitals ▪ Pharmacies ▪ Vision providers

MEMBER WEBSITE CONTENT	
Health Information	➢ Wellness programs and health conditions ➢ Health and wellness tips ➢ Appropriate use of the emergency department ➢ Availability of care management and disease management ➢ Forms and brochures
Other Helpful Information	➢ How to access interpreter services ➢ Pharmacy formulary and preferred drug list ➢ Pharmacy conditions for coverage and utilization limits ➢ Behavioral health information ➢ Current and archived quarterly member newsletters ➢ Preventative health tips ➢ Member satisfaction survey ➢ Self-management tips ➢ Non-emergency transportation ➢ Frequently asked questions ➢ Enrollment broker toll free number for enrollment questions
Links to External Partners	➢ Nebraska MLTC ➢ Enrollment Broker ➢ Medicaid Eligibility website ➢ Other state agencies ➢ Social agencies or supports
What's New	➢ Identifies newly added sections
Secure Member Portal	
Our secure portal for members (and caregivers) requires validated login and password credentials for access and is designed to further enable interactions with members, provide access to information and complete routine transactions. Core content includes:	
Eligibility Check	➢ Obtain PCP assignment, health plan assignment and copayment information
Authorization Check	➢ Review status of pending prior authorization submissions and historical submissions
Claim Status Check	➢ Review pending claim submissions
Self-Service Order Tool and Repository	➢ Review order status for a replacement ID card and new member materials such as member handbook
Member Toolbox	➢ Place over-the-counter orders, request a new ID card, print a digital copy of the ID card, request a change of PCP, send notifications of change in address, etc
Member Message Center	➢ Published member messages from public environment ➢ Secure message board to deliver personal content and messaging ➢ Access to correspondence ➢ Correspondence preference management capabilities

Provider Search Function

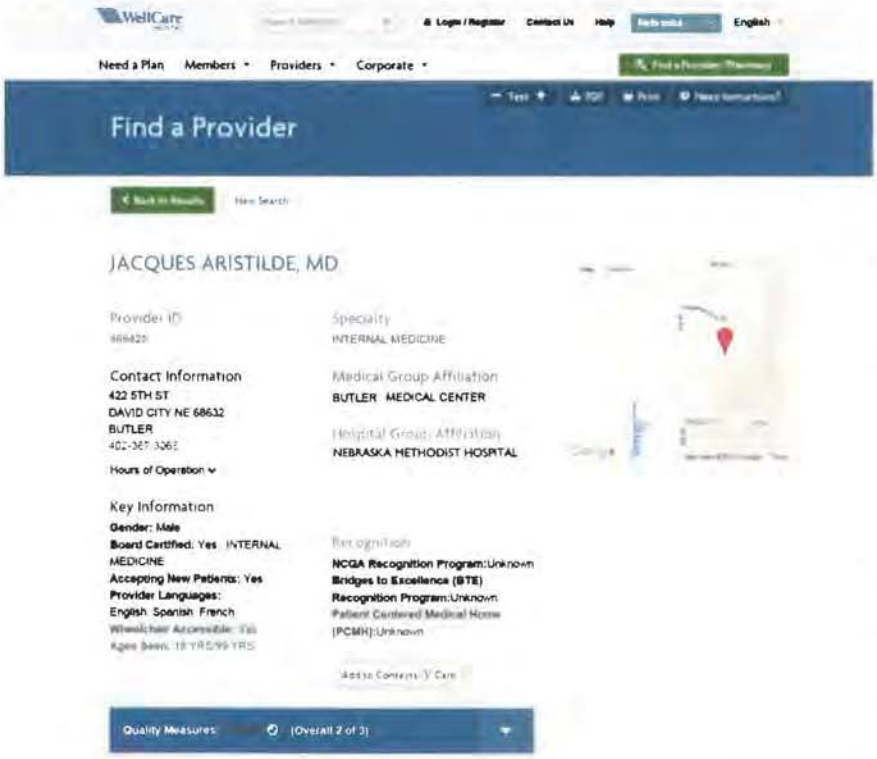
Figure 5



Our Find-a-Provider, online searchable provider directory tool makes it easy for members to search for providers and then alter, refine, and update their search results through intuitive refinement tools. Our tags and naming conventions are set up to meet members' health literacy needs when searching, so they can use common language such as "heart" to search for cardiologists, as an example. This tool also quickly allows members to refine their search based on the provider's gender, languages, accessibility considerations, provider and specialty types and distance from a user-chosen location, whether work, home, or their current location. Provider information is updated daily. Individuals do not need to login for access.

Another key feature (**Figure 5**) is the comparison tool. Using the same intuitive search capability, up to three providers can be selected and compared to each other. This feature helps members further evaluate provider options. The initial search response provides information that includes telephone numbers, service site addresses and contact information. Additionally, distance and navigation information is readily accessible from this first search result list.

Figure 6



More detailed information (**Figure 6**) is available with a simple click on the provider's name. In addition to providing the summary information, details on credentialing status and other key items are also available. We also include further explanations on the meaning, reference, or importance of concepts such as board certification which may not be initially well understood by many members. PCPs, specialists, and other providers not accepting new patients will be identified. Hours of operation will include non-traditional hours (before 8:00 a.m. after 5:00 p.m., or any weekend hours) if available.

Mobile Technology

Our mobile application for members includes many helpful and educational resources and is available for Apple and Android devices in English and Spanish and at no cost.

- Features available without logging in include:
  - Find-A-Provider tool, as shown in **Figure 7**, with advanced quick care (urgent and hospital emergency) service locator.
    - Similar to our online tool this electronic, searchable provider directory makes it easy for members to search for different providers and then alter, refine, and update their search results through intuitive refinement tools. This is enhanced by the 'use your location' extension that smartphones can offer – allowing members to find providers and quick care centers near their current location.
  - Messages from WellCare
    - We are able to send messages to members about important, time relevant items – like reminders about flu shots, upcoming enrollment periods, or changes in benefits.
  - Contact Us
- Features available after logging into the secure area of the application include:
  - ID Card
    - If a member needs to see a copy of their ID card but does not have it on hand, they can look up their ID card. They can also send it to their provider by email or fax.
  - Wellness Services (Care Gap)
    - Members will be reminded of care gaps, PCP's name and phone number and scheduled appointments as shown in **Figure 8**.

Figure 7

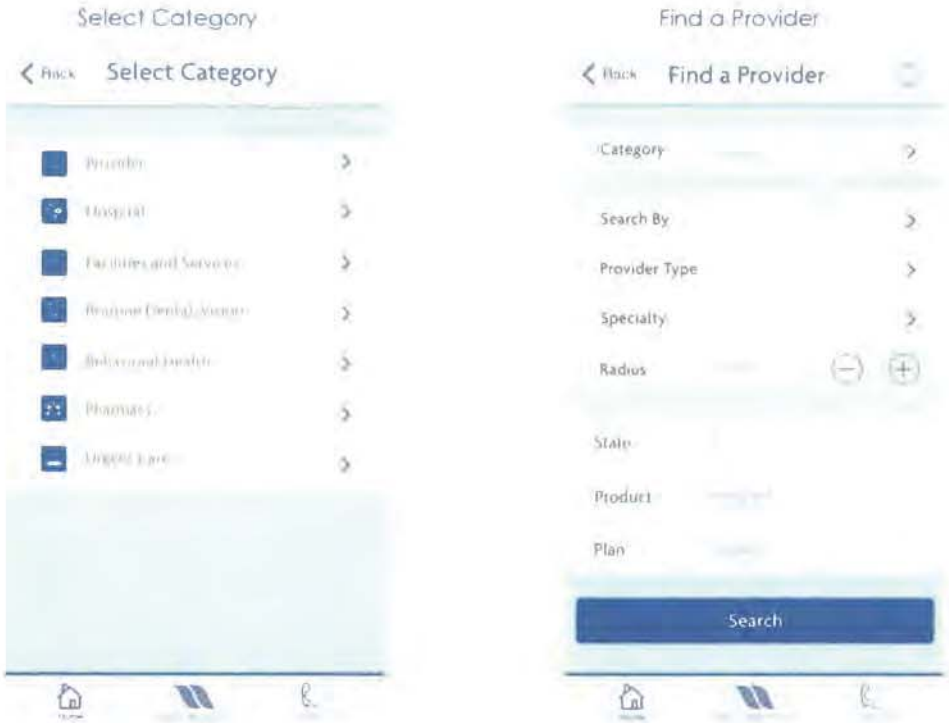


Figure 8

Since the mobile application is so valuable to our members we use a number of different ways to communicate these advantages to members, including but not limited to newsletter articles, messaging in wellness materials, and verbal communications during sessions like those with care managers or disease managers.

Our mobile application software allows us to report on member usage including:

- Total downloads, which includes types of phones like Apple and Android
- Feature Usage Report - Number of visits to some of the functionality
  - Used find-a-provider
  - Viewed, faxed and emailed ID card
  - Viewed messages
  - Looked for quick care centers
  - Viewed wellness services

Attachments

Attachment 31a_KY_CAID ADHD Trifold

Attachment 31b_KY CAID Preventive Health Guide 092011

Attachment 31c_GA CAID OTC Brochure ENG 102014

Attachment 31d_GA CAID MBR Newsletter ENG 042015

Attachment 31e_GA CAID Prenatal Care Visit Form 2015

Attention Deficit/ Hyperactivity Disorder

Does your child have trouble paying attention?

Does he or she talk nonstop or have trouble staying still?

Does your child have a hard time controlling his or her behavior?

For some children, these may be symptoms of attention deficit/ hyperactivity disorder, or ADHD.

Attention Deficit/ Hyperactivity Disorder

What is attention deficit/hyperactivity disorder, or ADHD?

ADHD is a common childhood disorder, and it may affect children differently. It makes it hard for a child to focus and pay attention. Some kids may be hyperactive or have trouble being patient. ADHD can make it hard for a child to do well in school or behave at home.

ADHD can be treated. Doctors and specialists can help.

Who can develop ADHD?

Children of all backgrounds can have ADHD. Teens and adults can have ADHD too.

What causes ADHD?

No one knows for sure. ADHD probably comes from a combination of things. Some possibilities are:

- **Genes**, because the disorder sometimes runs in families
- **Lead** in old paint and plumbing parts
- **Smoking and drinking** alcohol during pregnancy
- **Certain brain injuries**
- **Food additives** like artificial coloring, which might make hyperactivity worse.

Some people think **refined sugar causes ADHD.** But most research does not support the idea that sugar causes ADHD.

What are the symptoms of ADHD?

ADHD has many symptoms. Some symptoms at first may look like normal behaviors for a child, but ADHD makes them much worse and occur more often. Children with ADHD have at least six symptoms that start in the first five or six years of their lives.

Children with ADHD may:

- Get distracted easily and forget things often
- Switch too quickly from one activity to the next
- Have trouble with directions
- Daydream too much
- Have trouble finishing tasks like homework or chores
- Lose toys, books, and school supplies often
- Fidget and squirm a lot
- Talk nonstop and interrupt people
- Run around a lot
- Touch and play with everything they see
- Be very impatient
- Blurt out inappropriate comments
- Have trouble controlling their emotions.

How do I know if my child has ADHD?

Your child's doctor may make a diagnosis. Or sometimes the doctor may refer you to a mental health specialist who is more experienced with ADHD to make a diagnosis. There is no single test that can tell if your child has ADHD.

It can take months for a doctor or specialist to know if your child has ADHD. He or she needs time to watch your child and check for other problems. The specialist may want to talk to you, your family, your child's teachers, and others.

Sometimes it can be hard to diagnose a child with ADHD because symptoms may look like other problems. For example, a child may seem quiet and well-behaved, but in fact he or she is having a hard time paying attention and is often distracted. Or, a child may act badly in school, but teachers don't realize that the child has ADHD.

If your child is having trouble at school or at home and has been for a long time, ask his or her doctor about ADHD.

How do children with ADHD get better?

Children with ADHD can get better with treatment, but there is no cure. There are three basic types of treatment:

1. **Medication.** Several medications can help. The most common types are called stimulants. Medications help children focus, learn, and stay calm.

Sometimes medications cause side effects, such as sleep problems or stomachaches. Your child may need to try a few medications to see which one works best. It's important that you and your doctor watch your child closely while he or she is taking medicine.

2. **Therapy.** There are different kinds of therapy. Behavioral therapy can help teach children to control their behavior so they can do better at school and at home.

3. **Medication and therapy combined.** Many children do well with both medication and therapy.

How can I help my child?

Give your child guidance and understanding. A specialist can show you how to help your child make positive changes. Supporting your child helps everyone in your family. Also, talk to your child's teachers. Some children with ADHD can get special education services.

How does ADHD affect teens?

Being a teenager isn't always easy. Teens with ADHD can have a tough time. School may be a struggle, and some teens take too many risks or break rules. But like children with ADHD, teens can get better with treatment.

What can I do for my teen with ADHD?

Support your teen. Set clear rules for him or her to follow. Try not to punish your teen every time he or she breaks the rules. Let your teen know you can help.

Can adults have ADHD too?

Many adults have ADHD and don't know they have it. Like ADHD in children and teens, ADHD in adults can make life challenging. ADHD can make it hard for adults to feel organized, stick with a job, or get to work on time. Adults with ADHD may have trouble in relationships. The disorder can also make adults feel restless.

ADHD in adults can be diagnosed and treated. For some adults, finding out they have ADHD can be a big relief. Being able to connect ADHD to longtime problems helps adults understand that they can get better. If you're an adult and think you may have ADHD symptoms, call your doctor.

Contact us to find out more about ADHD.

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National Institutes of Health
NIH Publication No. TR-08-3572

IV.F MEMBER SERVICES AND EDUCATION

32. Discuss the MCO's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the MCO would use to effectively welcome members. *(Page limit 3 pages)*

BRINGING MEMBERS INTO THE WELLCARE FAMILY: OUR APPROACH TO WELCOMING MEMBERS

Our comprehensive member onboarding strategy begins with our new member welcome packet, sent to members within ten calendar days of notification of enrollment. In this welcome packet, members are made aware of how to access health care benefits, the comprehensive information and tools on our member website, our member services contact center, and our 24-hour nurse line.

Welcome Calls

All new members, including reinstated members, are automatically scheduled for a welcome call within 15 business days of the date we send the welcome packet. Welcome calls are administered in both English and Spanish and a total of six contact attempts are made. In the event the member cannot be reached, a letter is sent asking the member to call member services at their convenience. We also initiate a process to identify alternative numbers using a phone append process through skip trace technologies, automatic pulls from incoming phone calls, case manager notes and outreach to provider offices. Members identified as potentially high-risk are contacted separately through care management. WellCare will report to MLTC on a monthly basis the members we are unable to contact after three attempts with the name, telephone number(s) and Medicaid ID Number.

Our welcome call includes the following components:

- Explanation of the Heritage Health program and confidentiality requirements.
- Availability of oral interpretation and written translations and how to obtain them free of charge.
- Verification of receipt of the member ID card and new member packet, and the initial PCP assignment. The welcome packet is resent if the member indicates it was not received or lost.
- Discussion of patient-centeredness, including the importance of making the first appointment with the PCP to obtain preventive services and care for an ongoing illness or condition.
- Offer of PCP appointment assistance to all members with a particular focus on those who face barriers to accessing care, are pregnant, or have chronic conditions.
- Assistance in changing PCPs should the member wish to do so. Members have the opportunity to change the PCP assignment at any time and are informed of this during this initial outreach.
- Assistance in obtaining social services such as those offered by the Women, Infants, and Children (WIC) program or housing agencies through our CommUnity Assistance Line. Once referred our CommUnity Assistance Line team assists the caller in finding and accessing needed services and tracking the callers' progress through the process.
- Verification of the member's address, current services and equipment, and the member's independence and lifestyle. This information is used for transition of care and care management.
- Health risk screening (HRS) to determine if the member is pregnant, identify chronic conditions, barriers to accessing care, special needs, or care coordination services. Before completion of the HRS, the member is given the opportunity to be transferred to a member services associate to discuss any health issues of concern or to have any other questions answered.

WellCare has successfully transitioned large populations of members in states newly adopting statewide managed care including Florida, Georgia and Kentucky. Using predictive dialing technologies we were able to meet the large initial volume and complete the call within the first 15 days of the member's

effective date. For example, in Florida alone we executed outreach welcome calls for more than 600,000 members prior to program effective date. Upon receipt of enrollment files we immediately begin outreach to welcome members, identify coordination of care issues, and provide materials.

Solutions for Members We are Unable to Reach

Our experience with government programs has led to an understanding of rural, economic, and social challenges which can make communications difficult, including a high rate of members we are unable to reach. As a result, we have implemented a robust Unable to Contact (UTC) program for all members to ensure we are able to reach and communicate with these members. Our new member operations and correspondence solutions leverage multiple data sources and methods for ensuring the ability to make contact with members. This includes skip trace technologies to identify alternative numbers when outreach attempts fail; case manager case notes of alternative or temporary contact numbers; outreach to provider offices; member alerts through our secure portal; and automatic pulls from incoming phone calls, incoming mail and secure portal logins when confirmed contacts are received. When we reach the member, we update the member record with the correct telephone number. This new number is then available to all member-facing associates. Our UTC process will also prospectively search for members who have had no activity for 12 months and automatically initiate the UTC process.

Identification of Primary Care Provider for Each Member

Our emphasis on building and supporting successful relationships between members and their PCP is unparalleled. Our selection and change processes reflect our patient-centered philosophy and our understanding of the critical and fundamental nature of the member/provider relationship in the managed care setting.

From our experience, we understand the importance of the PCP/member relationship and the value of establishing that connection as soon as possible – each member requires individualized support. We have found that having the Enrollment Broker capture the member's selection of their desired PCP at the time they choose a health plan promotes a smooth transition to managed care. If the 834 file indicates the member has not made a choice of PCP assignment, they are auto-assigned upon enrollment using a hierarchy that includes existing PCP, former PCP, family's history with a PCP, geographic proximity, language spoken and PCP quality tier. We also reach out to members without an auto-assignment to help them proactively select a PCP if possible. Members may change PCPs at any time.

ALTERNATIVE METHODS TO ENGAGE MEMBERS WHERE THEY ARE

WellCare has found that our member welcome calls and welcome packets, as well as strong PCP connections, are effective ways to connect with new members. We propose to continue this process, in accordance with the requirements of the RFP, for Heritage Health members. In addition to welcome calls, we are deploying a number of additional strategies, which are outlined below, to connect with our Heritage Health members, understanding the diverse geographies and populations we would be serving in Nebraska.

Figure 9

Welcome Rooms

In addition to our primary office in Lincoln, we will offer Welcome Rooms (**Figure 9**) in key locations across the state, including in Omaha, Kearney, Scottsbluff, and Norfolk. Housed in strategically selected, high traffic, retail shopping areas close to social services in the neighborhoods and communities where

our members live, work and frequent, our Welcome Rooms are designed and equipped to engage the community by being outreach centers and walk-in member service hubs. Members and families can meet face-to-face with a member service representative at a local Welcome Room to get personalized attention to their needs, learn more about the Heritage Health plan, or receive information on important health topics. These locations are intended to be a destination point for our members and offer computers, internet access and activities geared toward our members and the community we serve. Welcome Rooms will host events such as children's reading and literacy support classes, health education classes, special needs resource navigation, and a variety of other activities and events for the community each month. Ongoing education will be available through monthly classes. At least one daytime and one evening class will be held per month.

Health*Connections* Model

We recognize the power of the social safety net community to help us reach members. Through our CommUnity Advocacy efforts built from our proprietary Health*Connections* model we partner with community organizations to locate and educate members. For example our Kentucky plan has established a partnership with HOTEL Inc. to locate homeless members. HOTEL Inc. offers an outreach program to find homeless residents, transition them into housing and connect them to health care. As WellCare members are identified, they are connected with our care management team and our services.

In Nebraska, we have already been building these relationships meeting with agencies from across the state and already have such partnership commitments including from Together in Omaha which helps people access documents like birth certificates and social security cards and from SPEAKOUT in Western and Central Nebraska which helps people apply for various benefits.

The beauty of the WellCare model is it benefits WellCare members and the community at large. Through these partnerships, not only will we be able to better reach and educate our members, anyone who accesses services through one of our partner agencies can also benefit from access to our one-of-a-kind CommUnity Assistance Line and CommUnity Command Center. These are the programs we use to connect people in need to social support services – such as housing assistance, food banks or transportation. Our database of programs in Nebraska already contains more than 5,000 groups.

Managing Large Member Transitions

WellCare is a leader in transitioning large numbers of members from other MCOs and from Medicaid and Medicare fee-for-service into managed care, including benefit carve-ins. Our outreach to members will be extensive whether it is through statewide new member orientation sessions, local welcome rooms, outreach at health fairs, or educational partnerships with advocates and other organizations. We will meet the members where they are to engage and empower them on the Heritage Health plan and their own health care.

IV.F MEMBER SERVICES AND EDUCATION

33. Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles. *(Page limit 5 pages)*

EMPOWERING OUR MEMBERS: STRATEGIES TO INFLUENCE MEMBER BEHAVIOR

After meeting with Nebraskans receiving Medicaid benefits, one thing that is clear is that members need multiple avenues of support and empowerment to take advantage of opportunities to appropriately access health care resources and adopt healthier lifestyles. The aged, blind and disabled members we met with, for example, shared how challenging it was simply to meet the basic demands of accessing the multitude of specialists, medications and equipment they need day in and day out. To help them take additional steps toward wellness, we recognize that our approaches have to be culturally sensitive, geographically appropriate and population specific.

WellCare uses a multi-pronged approach to empower our members to access health care resources appropriately and adopt healthier lifestyles, this includes all member-facing associates whether they be a member services associate talking to a member who is new to Heritage Health, a care manager working with a member to develop a care plan, a CommUnity advocate talking to a member at a health fair, or a member advocacy associate holding class in a welcome room. We broadly define health education as any opportunity to provide members information to help them make an informed decision regarding their health care and influence behavior. See **Figure 10** for a sample of our member touchpoints.

Figure 10

HEALTH EDUCATION AND OUTREACH METHODS	
Welcome Rooms	- Outreach centers and member walk-in service hubs with daytime and evening classes to educate members.
Welcome Calls and Health Risk Screenings	- Educates members on Heritage Health program and provides assistance in appointment setting and referrals to social services - Conducts health risk screening to quickly identify health issues and connect members with appropriate resources.
Member Services Contact Center	- Care gap alerts trigger associates to set appointments to close gaps in care while the member is on the phone. - 24-hour nurse line educates and triages the member to appropriate services. - Facilitate access to health education programs and health care resources.
Centralized Telephonic Outreach Program	- Outreach to members to explain care caps and initiate a three-way call with the member's provider to help set-up appointment to close the care gap.
Member Engagement Unit	- Outreach to members with recent emergency department visits, members new to care management and discharge follow-up.
CommUnity Assistance Line	- Connects members with social services to mitigate the impact of social determinates on health.
CommUnity Advocates	- Statewide health education and outreach activities in the communities our members live and work.
Care Managers	- Outreach to high risk members in person or telephonically based on acuity. During assessment and care plan development members are educated about their conditions, how to access information about services, and the appropriate use of the emergency department.
Disease Managers/Chronic Disease Coaches	- Provide members a broad range of educational materials and tools to help members in self-management prevent triggers that could place them in higher acuity levels of need. These include such items as mailings on

Health Education and Outreach Methods	
	managing diabetes or controlling environmental factors that exacerbate asthma symptoms.
Member Website, Mobile Application and Social Media	▸ Provides access to a wealth of educational material, and benefit information to empower the member

Member Story

The Empowerment Model in Action

A 55-year-old member had a history of multiple chronic conditions including COPD, congestive heart failure, diabetes, neuropathy, depression and smoking. The member came to WellCare in 2014, and she entered our intensive care management program after a below the knee amputation. Besides needing support through her recovery and an active desire to quit smoking, the member entered care management with multiple needs including:

- A lack of understanding of the importance of weighing herself daily to help manage her congestive heart failure
- Difficulty with her oxygen provider
- Difficulty getting to the pharmacy to pick up medications
- Challenges getting to a podiatrist
- Inability to get eye exams because of lack of knowledge about benefits

The WellCare care manager took several steps including:

- Supporting the member to complete her physical therapy
- Educating the member on the importance of CHF management, having an action plan and providing her a scale to weigh herself daily
- Supporting and coaching to help her quit smoking, which she has done without any cessation aids
- Connecting her with a podiatrist
- Educating the member on mail-order pharmacy options allowing her to get direct access to her medications
- Assisting with changing her oxygen provider
- Providing the member with vision information, resulting in the member receiving new glasses
- Connecting the member to job training and placement services as well

Today, this member is now independent and uses prosthesis. She drives and is walking around her block. She has started school and is working to get her Master's degree with a goal of getting off of Medicaid.

In addition to these broad member-facing education and outreach activities, we use value-added services and our Health*Connections* model to influence member behavior.

Influencing Member Behavior To Access Resources

Our specific strategies to influence member behavior to access resources include a focus on reducing non-emergency use of the emergency department, improving birth-outcomes and prevention-focused physical and behavioral health services.

Reducing Non-Emergency Use of the Emergency Department through Increased Access

The issue of inappropriate emergency department use is complex, requiring a multi-level approach. Our strategy includes services to reduce barriers to care including, as a sample, those in **Figure 11**.

Figure 11

Helping Members with Appropriate Use of Emergency Departments	
Emergency Department Diversion	▸ Our care management team contacts members who inappropriately use emergency department services to determine the underlying issues and connect them to the most appropriate, cost-effective services and resources.
Supplemental Transportation	▸ Reimburses friends and family who provide supplemental transportation to

Helping Members with Appropriate Use of Emergency Departments	
	members to their doctor appointments.
24-Hour Behavioral Crisis Line	- Provides access to a 24-hour behavioral health crisis line.
My WellCare Mobile App	- Provides members with easy access to the member ID card, find-a-provider tool, quick care (urgent care and hospital services locator), contact us, and wellness services which includes care gaps.

Improving Birth-Outcomes

We support and educate pregnant Heritage Health members on the importance of prenatal and postpartum care through a variety of strategies aimed at engaging expectant mothers early in their pregnancy and providing guidance, information, and support including those illustrated in **Figure 12.**

Figure 12

Helping Members Toward Healthier Pregnancies	
Prenatal Care Management	- Face-to-face contact with WellCare care managers to encourage pregnant women to practice good prenatal care.
Community Baby Showers	- Free community baby showers for new and expectant mothers that focus on providing mothers with critical health information for themselves and their babies, and successful parenting techniques. A gift basket and opportunity to participate in a raffle is also provided.
Stroller/Portable Playpen Program	- Rewards members who complete prenatal and postnatal care with a stroller or playpen.
Doula Services for Pregnant Youth	- Doula services for members who live in a group home or in home placement where there is minimal parental support with a goal of improved birth outcomes, reduced pre-term births, and improved prenatal care.

Prevention-focused Physical and Behavioral Health Services

Co-existing behavioral health needs, chronic medical illness, and social challenges occur among our higher-risk cohorts today. In addition to our integrated care management support, we offer prevention focused services to coordinate and integrate physical and behavioral services as shown in **Figure 13.**

Figure 13

Supporting Co-Morbid Physical and Behavioral Health Needs	
Comprehensive Peer Support	- We work closely with peer and peer supports as they provide substantial support, information, education, guidance, and coaching for members, particularly when it comes to medication.
Family Support Specialists	- A partnership with Nebraska Family Support Network where families receive counseling on the side effects of the member's condition, depression, anxiety, and behavior modification/coaching.
COBALT Therapies	- Free online cognitive behavioral therapy. Web-based tool that offers behavioral health self-management tools for a variety of conditions.

Influencing Member Behavior to Adopt Healthier Lifestyles

Improving Overall Health and Wellness

WellCare has developed a set of value added services to reach all Heritage Health members across the state to educate and empower them to adopt healthier lifestyles. These value-added prevention focused services seek to address a variety of chronic conditions including diabetes, asthma, cardiovascular related conditions, obesity and other diseases and include those shown in **Figure 14.**

Figure 14

VALUE-ADDED BENEFITS AND SERVICES	
Healthy Rewards	➢ Rewards members who complete specific preventive health, wellness and engagement milestones, such as PCP visits, well child visits, and cervical screenings, with a reloadable healthy rewards debit card.
Weight Watchers	➢ A free six-month membership to Weight Watchers.
Over the Counter (OTC) Benefits	➢ A $25 head-of-household monthly OTC allowance to promote self-directed prevention and maintenance. Members may use our OTC catalog to select items such as toothbrushes, first aid items and vitamins that are then delivered to their home. These items are not typically covered by Medicaid.
Discount Card	➢ Provides monthly discounts beyond what is available to the general public from pre-selected retailers allowing members to purchase needed items such as milk, bread, and detergent at a discount.
Tobacco Cessation Program	➢ Supplements Tobacco Free Nebraska's smoking cessation services by providing educational materials, gum, patches, lozenges, and help with obtaining counseling.

Improving Health Outcomes through Community Engagement

Disadvantaged and vulnerable circumstances impact the availability and accessibility of health care and influence lifestyle choices that impact health outcomes. Some of our many community engagement activities are detailed in **Figure 15**.

Figure 15

HELPING TO MANAGE SOCIAL DETERMINANTS OF HEALTH	
Welcome Rooms/Concierge	➢ Provides support for medical and non-medical needs including application assistance, transportation assistance, community support needs.
Health Fairs	➢ CommUnity advocates attend and participate in health-focused events to share information, resources and education concerning a variety of health topics such as diabetes management, back-to-school health, the importance of physical activity and general overall health and well-being.
WellCare Days	➢ On-site events called *WellCare Days* to promote and educate members on health plan resources and health information. Conducted in key locations and agencies across the state to conveniently provide members with health education, information and benefit assistance on site.
Health*Connections* Activities	➢ Community-based health and wellness events leveraging existing programs. ➢ HealthConnections Councils focusing on identifying creative and innovative ways to sustain the social safety network. ➢ CommUnity Assistance Line to connect members to social services.

Health*Connections* Model

WellCare understands the correlation between environmental factors and health outcomes and created the Health*Connections* model to address it. Applying research-based quality improvement methods we focus on population health metrics that will improve the overall health for Nebraskans by:

- Identifying needs through an analysis of key population metrics, by county and age, such as the
  - Percentage of Nebraskans who smoke, have diabetes, are overweight or obese, have limited access to healthy food, face severe housing problems, or are homeless
  - Number of deaths by suicide, mentally unhealthy days, and low birth weights
  - Population ethnicity

- Meeting with advocates to create a state-specific inventory of community programs and services
- Working within the community to identify opportunities to develop new programs or expand services
- Creating self-sustaining programs through the use of grants and business associate agreements targeted at the specific needs of our members

As part of our Health*Connections* Model, WellCare has developed numerous strategies that encourage our members to adopt healthier lifestyles. Below is an example of our strategy in addressing food insecurity.

Tackling Food Insecurity

The United States Department of Agriculture (2014) estimates that one in five children and one in seven adults in Nebraska face food insecurity. On average, 180,000 Nebraskans access the Supplemental Nutrition Assistance Program each month. See **Figure 16** for limited access by county. WellCare attacked the issue of food insecurity head on by creating a Healthy Food Access Initiative. By aligning all the community engagement strategies around the topic of healthy food access, WellCare accomplished the following in 2014 across 12 different states:

Figure 16

CommUnity Activities

- Hosted or participated in 803 total activities related to nutrition and healthy food access reaching nearly 600,000 people
- Collaborated with more than 18,000 stakeholders related to nutrition and healthy food resources

Social Service Utilization Support

- Referred more than 800 people to more than 1,400 local nutrition and healthy food resources
- Bridged more than 50 gaps in needed nutrition and healthy food resources

CommUnity Health Investment Program

- Launched seven healthy food access programs in three states to increase participation in WIC/SNAP by doubling benefits at Farmers Markets
- Increased access and purchase of healthy food by 85 percent among more than 65,000 participants

In Illinois in particular, our local CommUnity Advocacy team partnered with a community-based non-profit and the local farmer's market association to offer a double coupon program for low-income families accessing Supplemental Nutrition Assistance Program (SNAP) benefits when they used their benefit at a local farmers market to buy healthy food options like fruits and vegetables. Called LinkUP Illinois, more than 40 farmer's markets now participate with health benefits for both the SNAP recipients and to the farmer's market vendors.

IV.F MEMBER SERVICES AND EDUCATION

34. Describe the processes the MCO will put in place to ensure the MCO does not restrict the choice of providers from whom the member may receive family planning services and supplies. *(Page limit 1 page)*

FREEDOM OF CHOICE FOR FAMILY PLANNING SERVICES AND SUPPLIES

WellCare believes in patient-centered services that provide tools and information needed for effective family planning as well as to establish and reach personal health goals. We strive to offer an extensive network of contracted family planning clinics, and we allow members freedom of choice for family planning services or supplies. In accordance with our policies and MLTC requirements, WellCare covers family planning services and supplies provided by any Medicaid provider.

WellCare encourages our members to receive family planning services through our network of providers to ensure coordination of the member's total care. Family planning clinics are an important component of our network development plan, and we will extend contracts to all identified Nebraska family planning clinics funded by Title X monies. We have learned first-hand, through our meetings with local providers and advocates the challenges members face in rural and frontier areas.

WellCare ensures members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside our provider network without restrictions by:

- Removing all referral requirements from family planning services and related supplies
- Configuring our core processing system to pay the Medicaid provider at no less than the Medicaid rate in effect on the date of service
- Educating members on freedom of choice through all avenues of member communication including the member handbook, member newsletter, member service and care management touchpoints
- Educating providers on freedom of choice through our provider contracts, provider handbook and all other avenues of provider communication

WellCare takes an active role in educating our members about the availability of family planning services including but not limited to education and counseling, physical exams, pregnancy testing, and contraceptives. Upon enrollment, WellCare provides members with information about the availability of family planning services through our member handbook. The handbook advises that family planning services are available at no cost and without a referral. Additional information about family planning services is available through our member website. The member website includes helpful information on a wide variety of family planning-related topics including contraception and pregnancy tests. For those members who are pregnant, WellCare provides a variety of tools and educational resources to promote family planning services. Our *Mommy & Babies Matter* book, provided to all pregnant members, offers valuable information about family planning services. Those members enrolled in perinatal case management receive additional education about family planning services and support in accessing these services after the birth of the baby.

In addition, through WellCare's EPSDT program, family planning services and counseling are offered to appropriate members. In accordance with our EPSDT program requirements, the provider makes available and encourages all pregnant women and mothers to receive, and provides documentation in the medical records to reflect, counseling and services for family planning to women and their partners. WellCare also provides community-based education on the importance of family planning services.

WellCare shares in MLTC's goal to improve birth outcomes. We are confident that our family planning services' policies, education and outreach efforts, and community engagement help our members to obtain valuable family planning services thereby increasing intervals between births, encouraging healthy pre-pregnancy behaviors, and addressing risk factors with better birth outcomes and healthy babies.

IV.F MEMBER SERVICES AND EDUCATION

35. Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the MCO has used for member education.

Describe how the MCO will provide equitable member education throughout the State. Provide examples and descriptions of how member education will be used to improve service coordination including:

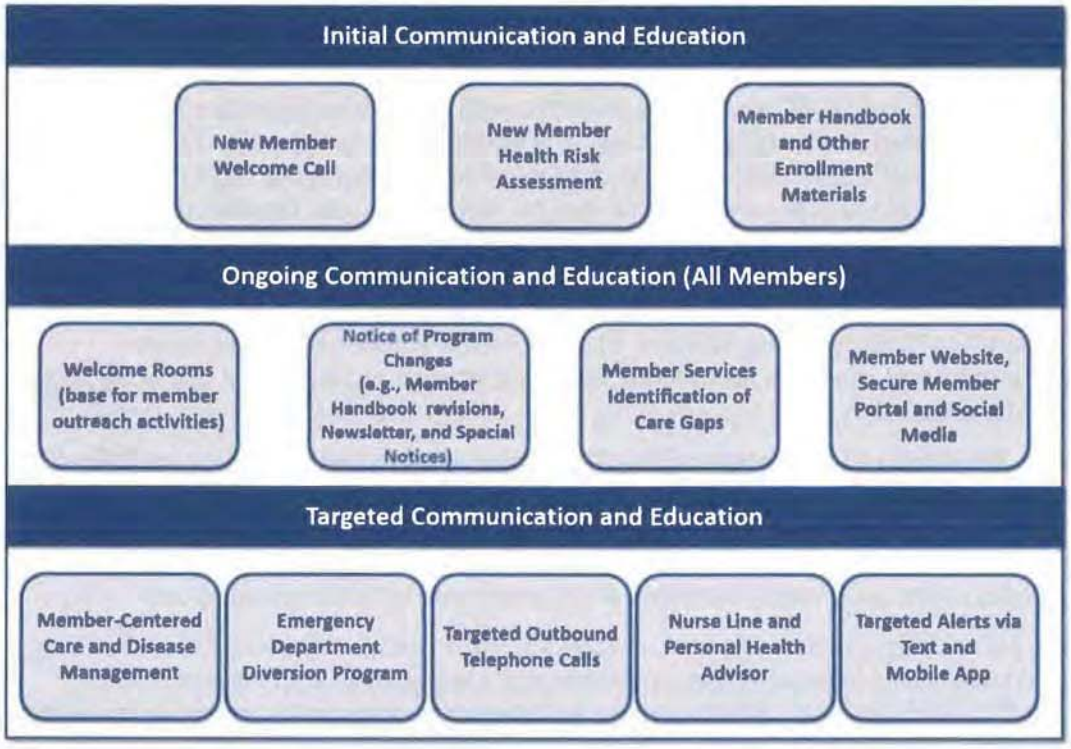
- Integration of physical, behavioral health and pharmacy services.
- EPSDT compliance.
- Appropriate emergency room utilization.
- The use of prenatal services.
- The use of technological tools, including social media and mobile technology.
- Partnership with community-based organizations for education and outreach.

(Page limit 10 page, excluding attachments)

EMPOWERING MEMBERS THROUGH COMPREHENSIVE MEMBER EDUCATION AND COMMUNICATION

Our comprehensive member education strategy includes initial, ongoing and targeted communication and education that is culturally competent and tailored to meet individual needs regardless of disability or education level. All mechanisms employed are specifically designed to help potential enrollees and current members understand the requirements and benefits of the plan as well as the supports available to empower them to navigate the health care system. Member education begins when the member joins our program and continues for as long as she or he is enrolled with us. It extends beyond the distribution of required information to include both broad-based and targeted outreach and member retention campaigns, as summarized in **Figure 17**.

Figure 17



Our member communication strategy is supported by:

- A comprehensive onboarding process for new members including solutions for those members we are unable to reach
- A toll-free line for potential enrollees and members
- Local community outreach aimed at educating potential enrollees and members about Heritage Health
- Welcome rooms that serve as outreach centers and walk-in member service hubs strategically located across the state
- Technology solutions including member website, mobile applications, and social media
- Member engagement unit that conducts telephonic outreach to members on a wide range of matters including welcome calls, satisfaction surveys, recent emergency department visits and discharge follow up
- Centralized telephonic outreach program where outreach specialists call members with outstanding care gaps to explain the gap, and set-up a doctor appointment to close the care gap
- Care managers and disease managers who proactively engage members through specific patient-centered interventions on a wide range of health education topics
- Our Health Connections Model to improve the health and vitality of our members by sustaining the social safety net

MEMBER HANDBOOK

Our member handbook will provide vital information related to benefit coverage and obtaining care and will comply with all the requirements described in this RFP. In addition it will comply with the requirements in 42 CFR 438.10(f) (6). Key information that will be available in our member handbook includes but is not limited to:

- Who we are, important contact information including member services toll-free telephone number, fax number, email address, mailing address and member website
- Services available under the contract including amount, duration and scope
- Role of the primary care provider (PCP) and choosing a PCP
- Procedures for obtaining benefits, including referral and authorization requirements
- Availability of non-emergency transportation and how to access
- Appropriate and inappropriate behavior when seeing a provider
- How to use the member identification card
- How to make appointments
- Extent to which members may obtain benefits, including family planning services, from out of network providers
- Prenatal services and post-partum care
- Hours of operation including the availability of the member services toll-free line and the 24-hour nurse line
- Preventive health services: Well child care, EPSDT guidelines
- How to change managed care organizations (MCOs) and when that is possible
- How to make a complaint and recommend a change in policy or service
- Care coordination, health education and promotion programs
- Notifying WellCare when you are pregnant or involved in an accident
- How to report fraud and abuse
- Second opinions
- Alternative methods or formats of communication and how to request interpreter or translation services
- Advance directives

- Information on the grievance and appeal process
- After-hours and emergency services and appropriate use of the emergency department
- Post stabilization care services
- Right to refuse services or treatments
- How to change PCPs
- Member protections, rights and responsibilities
- How to access Medicaid State Plan benefits and LTSS
- Cultural Competency
- Smoking cessation
- Indian Health Services/Tribal 638/Urban Indian Health
- Community resources and the CommUnity Assistance Line
- Patient confidentiality and HIPAA
- Contact information and the role of the Ombudsman
- How to report suspected abuse and neglect
- How to access behavioral health services
- How to contact the enrollment broker
- Roles and responsibilities
- Value added services
- Family planning
- Coordination of benefits and third party liability
- Getting help on issues surrounding housing, education, food, physical and sexual abuse and violence
- Getting help on behavioral health and protective factors

The MLTC-approved member handbook will be available in both English and Spanish and written at a sixth grade reading level. WellCare will publish the handbook to our member website with hard copies available upon request. Our members are informed of the availability of hard copy in the welcome packet and are asked to call member services to obtain one.

The handbook will be updated once a year and revised as needed to incorporate changes to the Heritage Health Plan and program. The updated member handbook will be made available to our members annually through the member website. For significant changes we will also provide our members written notice of the change at least 30 calendar days in advance of the effective date. This notice will include instructions to call member services if they would like a hard copy. Our draft member handbook is included as an attachment to this question.

CORE MEMBER EDUCATION OUTREACH

Our consistent focus on the member is supported by direct engagement with our members throughout their enrollment. This is accomplished through a wide variety of core activities including our welcome packet, welcome call, member newsletters, inbound calls to our member services contact center, and digitally through our member website and secure portal. WellCare recognizes that all member materials will be submitted to MLTC in the timeframes outlined in the Heritage Health contract.

Welcome Packet and Welcome Call

Member education begins with our welcome packet and welcome call. The welcome packet is sent within 10 calendar days of enrollment and is followed up with a welcome call during which the Heritage Health program and WellCare of Nebraska's role is explained, patient-centeredness is discussed, assistance in obtaining social services through our CommUnity Assistance Line and PCP appointment setting is offered.

Member Newsletters

Our quarterly newsletters (**Figure 18**) educate members on a variety of health, wellness, benefits and requirements of the plan including:

- Information on chronic illnesses and ways to self-manage care

- Behavioral health
- EPSDT screenings, reminders of flu shots and other prevention measures at appropriate times
- Medicare Part D issues
- Cultural competency issues
- Tobacco cessation information and programs
- HIV/AIDS testing for pregnant women
- Other health-related topics

The newsletter is available in English and Spanish. Other languages are available upon request as well as alternative formats. The newsletter will be available digitally on our website and mailed to members on request. WellCare will work closely with MLTC as to suggested topics for our Nebraska specific newsletter.

Figure 18

Member Contact Center

Our member services contact center offers well trained contact center associates who are knowledgeable about the Heritage Health Plan to help members and prospective enrollees understand the benefits and requirements of the plan, answer questions and facilitate resolution of issues. Our member services associates are alerted to care gaps when talking to members and initiate a three way call to schedule an appointment with the member's PCP and arrange transportation if needed. An automated reminder call occurs 24 hours before the appointment.

Member Website

Our Nebraska website will be an important communication tool to inform, educate and communicate with members. It will also be an avenue through which we promote health, wellness and service to our members. We offer a website for the general public allowing both existing members and potential members to access general information without any login credentials. Our secure member portal requires validated login and password credentials for access.

Innovative Member Education Solutions

In addition to core functions, WellCare uses a variety of innovative member eduation solutions such as community outreach associates, welcome rooms, a member engagement unit, outreach specialists who close care gaps, our mobile application, social media, web-based tools, and the Health*Connections* Model.

Nebraska Based Community Outreach Associates

Our integrated care management program is based on identifying the needs of our members; outreaching to them where they live; understanding how they prefer to engage with the health care system; facilitating their access to care; and helping them whenever, wherever and however they need us. Our community outreach associates are hired locally and have knowledge of the community including community services and partners. These associates are trained on compliant and effective engagement with prospective enrollees and members. Our community outreach department will support our integrated care management program through dissemination of information and education related to programs offered by the state of Nebraska and community organizations. Specific goals of the community outreach department include educating target audiences about the availability of health care coverage, and providing sufficient

information to promote and encourage enrollment and retention within the program.

Activities designed to achieve our community outreach include:

- Participation and sponsorship of educational events and health fairs
- Dissemination of MLTC-approved outreach materials
- Hosting table top events at approved community venues
- Partnering with organizations that have a primary focus on the well-being of children, families, the elderly and special populations
- Increasing awareness within the provider community to promote referral opportunities into the program
- Providing wellness information through social media, such as Facebook
- Promoting cultural awareness to reduce barriers to program access

In 2014, WellCare participated or hosted more than 5,000 total community activities reaching more than one million community stakeholders. These included peer support groups, children's dental days, car seat safety, healthy food access programs, baby showers, homeless outreach and more. WellCare also reached community stakeholders from diverse cultures and backgrounds including African American (299,000), Asian (221,000), Hispanic (260,000), Native American (13.000), and Native Hawaiian (12,000) cultures as well as many segments within the disability community (195,000) across more than 175 counties in seven different states.

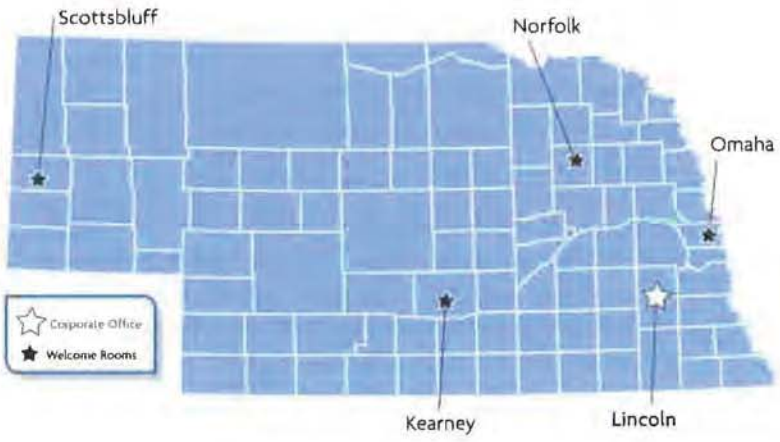
In Kentucky, we participated or sponsored 713 events and activities in 2014 with nearly 632,000 individual community touches.

WellCare intends to bring this focused support to the state of Nebraska. To this end, we have met community stakeholders from across the state to identify opportunities for collaboration. In meeting with these partners, we learned about several initiatives that offer opportunities to connect with members and the community-at-large.

Welcome Rooms

Our Welcome Rooms, strategically located in neighborhoods and communities where enrollees live, work, and frequent, are equipped to function as outreach centers and walk-in member service hubs. Here members and families can meet face-to-face with a member services associate and receive personalized attention to their needs. Ongoing education will be available through monthly classes. At least one day- time and one evening class will be held per month. Our welcome rooms provide an ideal opportunity for members to learn more about the Heritage Health Plan and receive information on important health topics. See **Figure 19** for our welcome room locations.

Figure 19



Member Engagement Unit

Our Member Engagement Unit conducts telephonic outreach to members on a wide range of matters including welcome calls, satisfaction surveys, recent emergency department visits, members new to care management and discharge follow up.

Centralized Telephonic Outreach Program

Outreach specialists call members with system identified care gaps to explain the gap and initiate a three-way call with the member's provider to help them set-up their appointment to close the care gap.

Care Management and Disease Management

Our care managers and disease managers proactively engage members through specific patient-centered interventions on a wide range of health education topics including appropriate use of the emergency department and medication compliance. They also teach the member how to access information about benefits and help the member access social services.

Mobile Application

Our mobile application for members includes many helpful and educational resources and is available for Apple and Android devices in English and Spanish. The mobile application allows us to send messages to members about important time relevant items such as reminders about flu shots. Through the secure portal of the mobile application, members will be reminded of care gaps, and scheduled appointments.

Social Media

WellCare engages with our Facebook community, which includes members, around topics such as health and social services and support, community engagement, and member and community education and services

Our social media policy requires we respond to inquiries made via social media within 12 hours. WellCare does not share protected health information (PHI) of any kind on social media without expressed permission from the member and/or designated guardian. Member comments on social media that include PHI are removed by WellCare. In 2016 we expect to further these efforts through the launch of our Twitter account, and Company blog. Visit our Facebook page at https://www.facebook.com/WellCareHealthPlans and our YouTube channel https://www.youtube.com/user/WellCareHealthPlan

Web-based Tools

Our website offers members a variety of web-based tools to help them manage their health. These include:

- Succeed Snapshot, a web-based health screening available online that a member can take in the comfort of their own home and at their own pace
- Cobalt Therapeutic Intervention, a web-based program for members with behavioral health needs to access counseling services online to drive their own recovery, as they see fit

Health*Connections* Model

Partnerships with community programs are a core part of our Health*Connections* model. Through these community activities, we support a wide range of community-based health and wellness activities aimed at empowering members to lead healthier lives. During the CommUnity Activities process we assemble and monitor available social safety net services and find the gaps and identify the corresponding impact of them on disadvantaged populations. We also partner with local communities and states to find innovative ways to sustain the safety net programs, while increasing their reach to our members, and integrating these services into member care plans. Key components of our model include:

My Family Navigator (aka Navigator): A searchable database of all public assistance programs that also provides the platform for community-focused statistical analyses and predictive modeling as well as a relationship management tool to use in collaborating closely with community organizations comprising the social safety net.

Social Service Electronic Health Record: A searchable interface created to assist our member-facing associates when they are searching for community-based programs and social services as well as tracking individual referral history by member, by provider and by service. Through this function, WellCare has referred more than 6,000 people to 21,000 community-based programs and services since the launch in 2011. In addition, WellCare identified and bridged more than 1,500 gaps in needed social services using traditional community mobilizing methods. This information led to the design and launch of nearly 100 different pilots leveraging evidence-based or evidence-informed wellness and disease management programs for member access and community benefit.

Member Education Plan

WellCare will develop a formal plan for ongoing education of our members prior to, during and after implementation of the Heritage Health Plan and will submit this plan to MLTC at least 45 calendar days prior to contract start date. WellCare has successfully implemented approved education plans in several states such as Hawaii and New York and in states newly adopting statewide managed care including Florida, Georgia, and Kentucky. See **Figure 20** for a summary of our member education plan.

Figure 20

Member Education Plan		
Member, Potential Member and Caregiver Education Plan		
Activity	**Timeline**	**Topics or Function**
Welcome Rooms	Open prior to go-live and continuing for duration of the program	▸ Serve as outreach centers and walk-in member service hubs to assist members or potential enrollees with specific questions, changes in PCP etc.
Statewide Orientation sessions	Beginning 90 days prior to go-live and continuing 30 days post implementation, then quarterly thereafter	▸ Who are we? ▸ Program overview including covered benefits, accessing care, role of a PCP and choosing a PCP, availability of transportation, grievance and appeal process ▸ Question and answer period
Member Outreach associates in place	30 days prior to go-live	▸ Conduct community outreach activities where the members are
Member Contact Center	Open 30 days prior to go-live or earlier as needed	▸ Answer member and potential member questions ▸ Assist with PCP assignment process
Member Website	Operational 60 days prior to go-live	▸ Provider search function ▸ Member collaterals ▸ Frequently asked questions
CommUnity Assistance Line	Operational 60 days prior to go-live	▸ Available social services catalogued and made available to prospective members and their

Member Education Plan		
Member, Potential Member and Caregiver Education Plan		
Activity	**Timeline**	**Topics or Function**
		families/caregivers
Member Engagement Unit	Operational 60 days prior to go-live	▸ Outreaches to members in need of care management services

Providing Equitable Member Education Throughout the State

WellCare uses multiple modalities of reaching members for the very purpose of ensuring we reach members in an equitable way regardless of where they live. We recognize the unique challenges of the rural, and particularly, frontier communities. Having met with the Center for Rural Affairs in Lyons, we are eager to build innovative partnerships to further support these goals. One step is making sure we have member facing associates located throughout the state. The other is to offer members multiple ways to interact with us including in-person, telephonic, web-based, email, text and chat. Activities and events are tracked to ensure we are reaching our members in the most effective manner. See **Figure 21** for a summary of examples and descriptions of member education to improve service coordination. Detailed examples follow the summary.

Figure 21

Summary of Examples and Descriptions of Member Education to Improve Service Coordination	
Integration of physical, behavioral health and pharmacy	▸ Community partnerships throughout the state to promote the integration of services and coordination of care ▸ Partnerships with health departments and regional health authorities on the distribution of materials to the entire population ▸ Health education for SPMI populations on obesity and chronic conditions ▸ Educational material on co-existing conditions including diabetes and depression, medication adherence, impact of smoking, impact of stress
EPSDT compliance	▸ Periodicity letters mailed to children birth-21 on their birthday month with a reminder of age appropriate preventive care services ▸ Care gap alerts on mobile application site ▸ Outbound calls to educate member on care gaps, schedule appointments, and arrange transportation ▸ Care alerts to member facing associates as to gaps in care whenever members call us. Associates educate member and offer assistance with appointment scheduling and transportation ▸ Using member incentives such as gift cards or distributing other low-dollar items
Appropriate emergency room utilization	▸ 24 hour nurse line directing members to appropriate setting ▸ 24 hour behavioral crisis line ▸ Outbound calls on recent emergency room visits ▸ Member handbook, newsletters and welcome packet ▸ Provider directory with urgent care look-up ▸ Find-A-Provider mobile application with advanced quick care service location ▸ Clinics in pharmacies and retailers to educate members on appropriate use of the emergency room ▸ Comprehensive outreach to homeless residents
Use of prenatal services	▸ Text4baby a free mobile information service designed to promote maternal and child health ▸ Healthy behaviors program rewards members who have had appropriate prenatal

Summary of Examples and Descriptions of Member Education to Improve Service Coordination	
	visits and timely postpartum care with a free stroller or play yard - Meeting with expectant mothers in the community to discuss importance of prenatal and postpartum care - Prenatal risk assessment and care management services for prenatal members

Use of technological tools, including social media and mobile technology	- Text4baby offering free text4baby pregnancy messages starting at enrollment, provides 3 texts per week through birth and weekly through baby's first 12 months
	- Mobile application available for Apple and Android devices includes:
	  ▪ Find-A-Provider advanced quick care service locator (urgent and hospital emergency)
	  ▪ Message to members about important, time relevant items such as flu shots or changes in benefits
	  ▪ Care gap reminders to members, including PCP's name and phone number and scheduled appointments
	  ▪ Member education campaigns promoting the mobile application
	  ▪ Reporting software measuring member usage including total downloads Find-A-Provider, viewed messages, searches for quick care centers, viewed wellness services
	- Cobalt Therapies online modules for anxiety, depression, insomnia and substance abuse
	- Succeed Snapshot online health screening tool
	- Social media content around
	  ▪ Health and social services and support
	  ▪ Community engagement
	  ▪ Member and community education and services

Partnerships with community-based organizations for education and outreach	- Nebraska based community outreach associates supporting our community-based partners throughout the state with our Health*Connections* model - Attending health fairs to distribute health related information and conduct appropriate screenings - Member referrals to community-based programs and services such as farmer's markets and farm-to-community mobile markets - Member referrals to community-based, evidence-based chronic-disease self-management programs offered through local Area Agencies on Aging - Hosting caregiver support and education programs through welcome rooms

Best Practices: An Example of Integration of Physical, Behavioral and Pharmacy Services

Our Georgia affiliate introduced our integrated model of care to Hope House, a residential substance and mental health program in the East region. After the initial meeting with Hope House, our member outreach team provided education - explaining benefit information, how to access to care and how to complete applications. Additionally, a care manager assessed pregnant members and evaluated high risk pregnancy related complications. Through this partnership, our Georgia plan now refers members to Hope House for services, and Hope House refers members to WellCare on an on-going basis for medical and behavioral health care management. Prescription oversight is an integral component of the care plan.

Best practices: An Example of Maximizing EPSDT Compliance

Our CAREConnects system supports our enterprise quality improvement goals by providing member services associates with care alerts when a member's record indicates he or she has not received an important health screening or service. The member services associate educates the member about the care gap and supports the member in taking action (i.e., scheduling an appointment). If an appointment is

scheduled, the member receives an automated reminder 24 hours before the scheduled appointment.

Best practices: An Example of Encouraging Appropriate Emergency Room Utilization

Our 24-hour nurse line team performs a risk assessment or triage of the health concerns, problems or symptoms. They then use a nationally recognized triage decision-making tool to assist the member in deciding whether to see their doctor, go to an urgent care center, or seek immediate emergency care.The use of the nurse line helps control costs and minimizes inappropriate use of the emergency room while delivering the highest quality care. This solution involves around-the-clock access to specially trained nurses who refer members to in-network providers, facilities, and support groups as well as provide assistance in scheduling much needed preventive appointments. Nurses who answer the 24-hour nurse line are able to assist the member in making an appointment with their PCP when appropriate as well as assist in locating the closest participating urgent care center for the member. ***In the fourth quarter of 2014, 65 percent of callers inclined to access the emergency room were diverted by the nurse line team to a lower level of care than originally inclined.***

Best practices: An Example of Technology Partnership

WellCare partners with national, state and local resources to identify community-based best practices while also testing additional programs. Our Georgia affiliate recently partnered with the East Central Public Health District to target children with asthma between the age of 5 and 9. This health district was selected because they have one of the highest rates of asthma-related emergency room visits in Georgia.

Under our pilots, the child is enrolled in a program through the school to manage their asthma and its triggers using an Ipod Touch. During weekly check in meetings, the school-based nurse or community health worker monitors the child's medication usage, trigger information and other factors to provide asthma education and support to the child and his or her family. In addition to this program, the local health departments also participate in the "healthy homes" initiative through which in-home supports are offered to the family to help reduce in-home triggers by introducing hypo-allergenic linens, reducing pet dander and so on. Using our proprietary Health*Connections* model, WellCare works locally to identify community programs like these to support families in their own community.

Partnerships with Community-based Organizations for Education and Outreach Example

WellCare engages with community based organizations who offer local and often innovative programs and services. For example, WellCare of Georgia works with a community organization called Help a Child Smile, a mobile dental program offering comprehensive dental services at local schools in 100 counties throughout Georgia. By contracting with Help a Child Smile, WellCare is connecting with non-compliant pediatric members as well as other children at their school, with their parent's permission, to ensure they receive their annual dental checkup. The CommUnity Advocacy team has been trained on completing community health needs assessments and traditional public-health community mobilizing techniques. So, as the pilot progresses, our team will assemble a Health*Connections* Council dedicated to the topic of dental coverage and expanding coverage. This allows WellCare to work with community partners to identify best practices and facilitate the expansion of a program like Help a Child Smile. In addition to the draft Member Handbook included in the required Attachment 5 attachments, we have included the following examples of member engagement materials.

Attachments:

- Attachment 35a_Member Newsletter
- Attachment 35b_Mommy & Baby Matters Booklet
- Attachment 35c_text4baby Brochure
- Attachment 35d_Cobalt Therapies Quick sheets
- Attachment 35e_Periodicity Letter

RESTORE™

"This program has been proven to help people sleep better and feel better."

(6 Modules)

Getting Started

1

- Insomnia
- Problematic sleeping habits
- Consequences of insomnia
- Realistic sleep expectations
- Set Goals
- Homework: self-monitoring of sleep

Stimulus Control and Sleep Restriction

3

- Stimulus control
- Cues which promote sleepiness
- Sleep restriction
- Medication
- Homework: Practice the above techniques

Sleep Hygiene

5

- Noise
- Exercise
- Napping
- Temperature
- Lighting
- Smoking
- Caffeine
- Alcohol
- Eating
- Sleep Hygiene Exercise

Mindfulness

6

- Mindful observing
- Mindful listening
- Homework: practice mindfulness, continue with sleep diary

Sleep Diary

Sleep diary: best if done every night

Relaxation Techniques

2

- Paced breathing
- Deep muscle relaxation
- Imagery-induced relaxation
- Self hypnosis
- Homework: Practice relaxation techniques

Cognitive Behavioral Therapy

4

- Identify unhelpful thoughts
- Challenge their validity
- Substitute more helpful thoughts
- "So what if..." Technique
- Worry Time
- Homework: Generate a list of coping thoughts

MoodCalmer ™

"This program helps people reduce depression and develop long-lasting improvements."

(4 Modules)

- Getting Started
- Explanation of CBT
- Initial questionnaires
- Psychoeducation
- Triggers
- Real life case studies introduced
- No Homework

Getting Started ❶

Challenging Thoughts ❷

- Pleasant activities
- Effects of reduced activity on thoughts
- Benefits of pleasant activities
- Activities to do alone and with others
- Rewarding yourself
- Activity: Pleasant Activity Exercise

Pleasant Activities ❸

- Cycle of negative thinking
- Negative automatic thoughts
- Common thinking errors
- Challenging negative thoughts
- Homework: Challenging thoughts exercise

Keeping Well ❹

- Keeping well
- Sleep
- Diet
- Exercise
- Activity: Complete sleep management plan and personal relapse prevention plan

Real Lives Each session includes case studies based on real patients experience using the program

FearFighter™

"Thousands of people have used this software program to help them overcome their anxiety, panic, and/or phobia."

(9 Modules)

- Overview of steps and activities
- Introduction to CBT, Anxiety, Panic and Phobia
- The Fight or Flight Response
- Find a Helper

Getting Started

1

2

How to Beat Fear

- Spot signs of anxiety
- Identify safety behaviors
- Keep a FearFighter™ diary

3

Anxiety Management

- Learn anxiety management techniques
- Exposure therapy
- Diaphragmatic breathing
- Progressive Muscle Relaxation

4

Challenging Thoughts

- Characteristics of negative thoughts
- Challenging thoughts exercise
- Recognize Thinking Errors

5

Core Beliefs

- Challenge core beliefs
- List the evidence
- Build alternative and more helpful core beliefs

6

Exposure and SMART Goals

- Practice exposure therapy
- Create a fear hierarchy with SMART goals

7

Exposure and Rehearsal

- Face triggers
- Work through fear hierarchy

8

Continuing Exposure

- Review exposure therapy
- Track progress

9

Maintaining Your Goals

- Deal with Setbacks
- Relapse Prevention
- Goal Rehearsal

OCFighter™

"Recognized for absolute clinical efficacy."

(9 Modules)

- Overview of steps and activities
- Introduction to CBT and ERP
- Benefits of OCFighter

Getting Started

1

- Identifying Triggers for your Rituals
- Measuring level of discomfort
- Real Lives: How Carol and Bill identified their triggers

Identifying Triggers

3

- Creating a fear hierarchy
- How To Create An Effective Goal
- Reviewing case study hierarchy

Goal Setting and Exposure

5

- Interactive ERP Review
- Dealing with many triggers at once
- Checking, contamination etc.

Continuing Exposure Part One

7

8

Relapse Prevention

9

- Using up free time and pleasant activities
- Tracking Progress
- Rituals And Cost
- Preventing relapse
- Staying well plan
- Booster Sessions

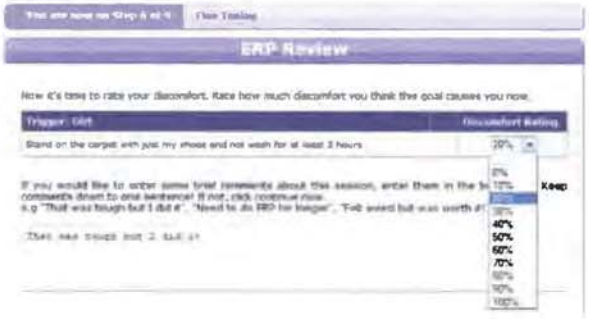
Continuing Exposure Part Two

- Interactive ERP Review
- Depression, alcohol, drugs, and pure obsessions
- Complete Working On Triggers
- Putting Triggers On Hold

6

Fine Tuning

- Interactive ERP Review
- Planning goals
- Working on triggers
- Common problems with ERP



2

Rituals and Their Cost

- Explanation of CBT model of OCD
- Explanation of exposure with ritual prevention
- Real lives: two case studies (Carol and Bill)

4

Obsessive Thoughts

- Trigger Log Activity Check
- Understanding obsessive thoughts
- Identifying thinking styles

SHADE™

"Demonstrated to significantly reduce substance use, drinking, binge drinking, hazardous use and depression."

(10 Modules)

- How to examine and evaluate life events
- Important information about alcohol, drugs and depression
- How to identify pros and cons of using

Getting Started

❶

Mindful Awareness

- How to monitor thoughts and behaviors in everyday life
- Examine the costs and benefits of drinking/using
- Learn about "Mindful Awareness"

❷

- How thoughts and behaviors are linked
- Analyze pros and cons in regard to changing situations
- Learn to experience routine activities in a mindful way

The "ABC Model"

❸

Developing a Change Plan

- Use 'Activity Log' to schedule one pleasant activity and one achievement activity each day
- Develop a 'Change of Plan' for current situation
- Learn more about experience of cravings and impulses

❹

- Learn about problematic ways of thinking common to depression and using
- Learn to manage problematic patterns
- Develop mindfulness skills

Managing Problem Behaviors

❺

- Learn about schema
- Identify problematic schema
- Learn how to develop alternative, balanced schema

Identifying Schema

❼

Problem Solving

- Learn and practice problem solving skills
- Develop Mindfulness skills

❻

Using Mindfulness

- Learn about 'Seemingly Irrelevant Decisions"
- Identify and manage the 'Breaking the Rule' effect
- Learn how to look after wellbeing

❽

Preparing for Life

- Learn strategies to help cope
- Learn to effectively refuse
- Develop an Emergency Craving Plan

❾

Relapse Prevention

- Learn about the importance of relapse prevention
- Develop their own 'Relapse Management and Prevention Plan

❿

SECTION IV.H GRIEVANCES AND APPEALS

36. Provide a flowchart and comprehensive written description of the MCO's member grievance and appeals process, including the approach for meeting the general requirements and plan to: *(3 pages)*

- 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 MCO will determine when the expedited process is necessary.
- Use data from the grievance and appeals system to improve the MCO's operational performance

(Page limit 3 pages)

WellCare Supports Important Protections for Our Medicaid Members

As a service-oriented organization, we communicate with members about their rights, including their right to express dissatisfaction or their right to request an appeal when services are denied, reduced, suspended or terminated. Grievances provide invaluable feedback about our members' experiences with us and the health care delivery system at large, so we strive to create an environment where our members trust that we take their concerns seriously and will address problems when they are encountered. Appeals are not just a basic right of enrollment but an integral part of our overall quality-oriented medical management program. ***Given the importance of grievances and appeals, our company policy prohibits delegation of these functions to subcontractors; instead, all are managed in-house.***

A Comprehensive Review of WellCare's Grievance and Appeals Processes

Our grievance and appeals system complies with Federal and State regulatory requirements and includes processes to receive, process, and report on member grievances and appeals. Our internal review process, which provides one level of appeal, allows members and providers to present new or additional information about the member's health so we may evaluate previously denied, reduced, or suspended services. As required, our grievance and appeals system includes access to the State's fair hearing system allowing members and providers at any time to appeal WellCare's decision to uphold the denial.

WellCare Provides Timely Acknowledgement of Grievances and Requests for Appeal

Upon receipt of a grievance or request for appeal, we assign the member's request to a coordinator who records the request in our database capturing information about the member's circumstances and prepares a written acknowledgement of receipt so the member is assured we have received the concern and are addressing it. Our letters use easy-to-understand language and are sent in the language in which the member has submitted the request. As an added measure, the English version of our letters includes information about how to request the letter in alternative languages and formats for those members requiring them. The letter is sent to the member within ten calendar days of receipt of the request.

WellCare's Grievance and Appeals Process

Our approach to meeting general requirements for grievances is demonstrated in the attached flow diagram (**Attachment 36a_Grievance Process Flow**). Upon receipt, the grievance coordinator researches the member's complaint. If the grievance requires input by another department, including clinical professionals for grievances involving clinical issues, the coordinator works with the department(s) to gather facts. If the grievance is from a member enrolled in care management, the coordinator contacts the care manager to inform him/her of the grievance and engage the care manager in the review which is especially critical when the issue pertains to care the member is receiving. Upon completion of the

research, the coordinator updates the database summarizing the issue, key dates associated with the matter (i.e., receipt date, date acknowledged), and the final disposition. The coordinator also prepares the grievance disposition letter explaining the research conducted, our findings, and the actions we have taken or will take. The grievance disposition letter is sent as expeditiously as the member's health condition requires but no more than 90 calendar days from the date the grievance was received.

For appeals, we do not give deference to the original adverse determination. As demonstrated in the attached flow diagrams (**Attachment 36b_Pharmacy Appeals Process Flow** and **Attachment 36c_Medical Appeals Process Flow**), upon receipt the reviewer begins investigating the request, including all aspects of clinical care involved, taking into account all comments, documents, records, or any other information submitted by the member or his/her representative without regard to whether such information was supplied or considered in the initial review.

Once the review is complete, the reviewer documents findings and makes a determination. If the request is approved, the reviewer enters the authorization in our Medical Management Platform and sends written notification to the member and provider (or triggers reprocessing of the claim if services have been rendered). If the recommendation is to uphold the denial, the reviewer forwards the request and supporting documentation to a Medical Director for final determination. While our internal review process does not require review by our Appeals Committee (only review by a physician with appropriate clinical expertise who was not involved in previous levels of review or decision-making), our Medical Directors may engage our Appeals Committee as an additional level of multi-specialty physician review to objectively evaluate the determination and the best interests of the member.

Upon completion of the review, the reviewer updates the database with a dated summary of the issue or request, key dates associated with the request (i.e., receipt date, date closed), and final disposition. The coordinator also prepares and sends written notice of the appeal decision, which includes the results and date of the appeal outcome, information about the criteria used for the evaluation, the rationale for the decision, and information about the appeal rights available to the member through the State's fair hearing system including how to request a State fair hearing. The notice also informs the member of his/her right to continue receiving benefits pending further review, how to request continuation of benefits and information that the member may be liable for the cost of any continued benefit received if the action is upheld in a hearing. For pre-service appeals, we issue notices as quickly as the member's health condition requires but no more than 30 days from the date the request was received, which is more stringent than the required 45 days in the RFP. ***In 2014, WellCare completed Medicaid pre-service appeals in an average of 15.4 calendar days.***

WellCare Ensures Decisions are Made by Individuals With the Appropriate Expertise

WellCare has specialized and separate teams who handle grievances and appeals. Our grievance team, operating within Member and Provider Communications, is comprised of 74 highly-qualified associates. Hiring skilled associates is a high priority so we seek individuals with at least one year of experience in customer service and give strong preference to those with health care and grievance job experience. We also have a highly-qualified appeals team aligned within our clinical services organization, which includes care management, pharmacy, utilization management, and behavioral health. Our appeals teams include 167 associates (five pharmacists, 17 supervisors, 34 pharmacy technicians, and 111 appeals associates including appeals coordinators and reviewers, and intake specialists). For clinical reviews, only health care practitioners who have appropriate training and experience in the field of medicine are involved in the case reviews. Because we offer an in-house pharmacy, behavioral health, and medical program, our clinical experts include pharmacy medical directors, staff psychiatrists, and medical directors of varied specialties. If necessary, we have external physician advisors for a same/similar specialist review.

Unbiased Reviews Through Individuals Not Involved in Previous Level of Review

To offer an unbiased evaluation of an appeal, it is important to ensure the decision-making process does not include those who may have been involved in the previous level of review, nor the subordinate of any such individual. When physician review is required at the appeal, **our reviewer identifies the physician involved in the previous level of review and excludes that physician from any part of the review, instead conferring with available medical directors or an external physician advisor as noted above.**

WellCare's Approach to Ensure Timely Reviews to Not Jeopardize Members' Health

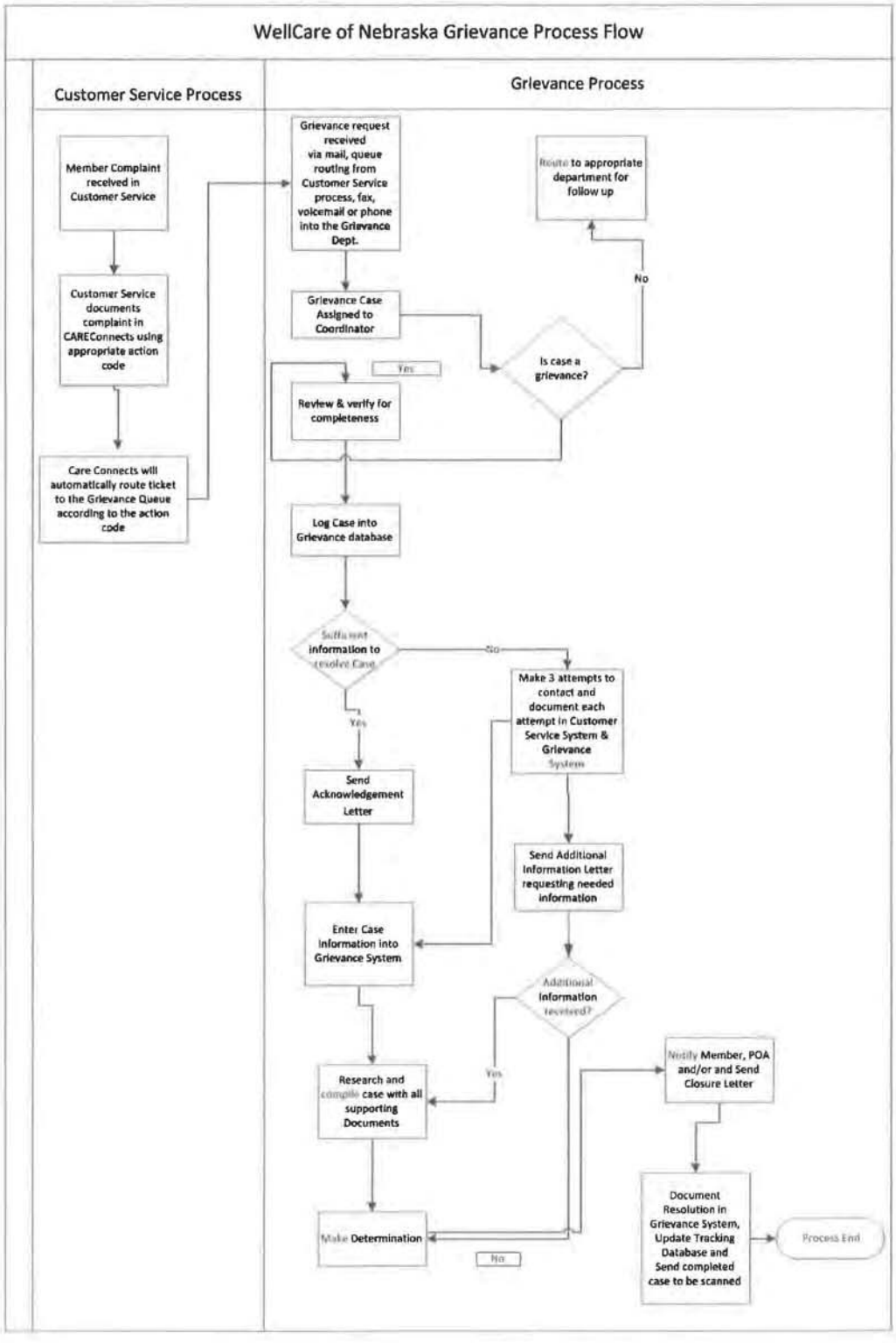
We offer expedited review of appeals when standard resolution could seriously jeopardize our members' life, health, or ability to attain, maintain, or regain maximum function. Members and providers may request an expedited appeal, which is evaluated for exigency by a clinical reviewer and medical director. Our staff, specially trained to evaluate standard requests, may also determine a member's clinical circumstances necessitate expedited review. If the request to expedite is approved, the reviewer proceeds with the review in an expedited fashion providing notice verbally and in writing within 72-hours of receipt of the request or identification. If the request to expedite is denied, we provide prompt verbal notice and mail written notice within two calendar days of the denial advising that the review is being processed under the standard timeframe of no longer than 30 calendar days from the day the appeal was received. In all cases, our policies prohibit punitive action from being taken against anyone who requests or supports a request for an expedited appeal.

Our Data-Driven Approach to Grievance and Appeals Improves Operations

Central to our grievance system is our proprietary grievance and appeals database, where all requests are captured and categorized to help easily identify trends and opportunities for improvement. Our multi-disciplinary Grievance Governance team meets weekly and is singularly focused on delivering an improved member experience. They do so by driving operational improvements through the routine analysis of grievance data. Using routine and ad hoc reports the team thoroughly reviews grievance data, identifies trends, reviews results of root cause analysis, develops actions to remediate issues negatively affecting members, and monitors performance. Appeals and grievance reports, including action plans, are presented to the Customer Service Quality Improvement Workgroup (CSQIW) and Utilization Management (UMC) and Quality Assurance and Performance Improvement Committees (QAPIC).

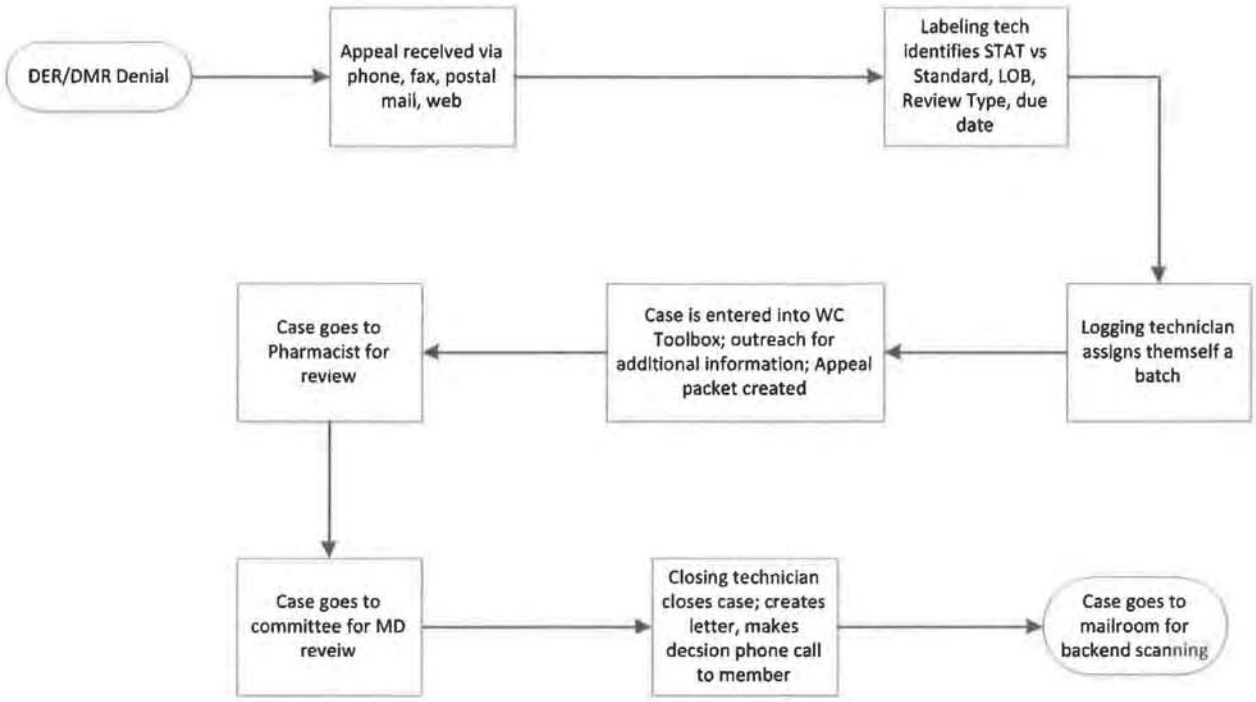
Through our disciplined approach, we have made significant improvements in our members' experiences. For example, we identified an issue of providers balance billing our members. In response, we implemented a Member Services team to personally assist members with balance billing problems and conducted provider education through our Claims team. As a result, **we successfully reduced balance billing-related grievances by 91 percent in three months**. We achieved similar success with non-emergency medical transportation (NEMT)-related grievances. In response to a negative trend, we implemented local "strike force" teams in Medicaid markets experiencing an especially high volume of grievances. These strike force teams were responsible for receiving grievance data and taking action by addressing the NEMT drivers' companies through telephone and face-to-face meetings. They also managed disciplinary action, including termination of poor performing contracts, and added new NEMT subcontractors. As a result, **we reduced NEMT-related grievances by 67 percent in seven months**.

We continue to invest in our grievance systems including its supporting technology. To that end, over the next 18 months we will fully deploy our new CAREPath system for appeals. CAREPath is our next generation proprietary application that will provide enhanced end-to-end tracking and monitoring of all grievances and appeals. The platform is designed to effectively manage the grievance system processes thereby providing a 360 degree view of the issue and workflow touchpoints. Built on the highly effective Pegasystem platform, this true workflow solution will provide a unified channel to handle grievances and appeals. Additionally, it will enable a faster, accurate and quality-controlled response to our members.

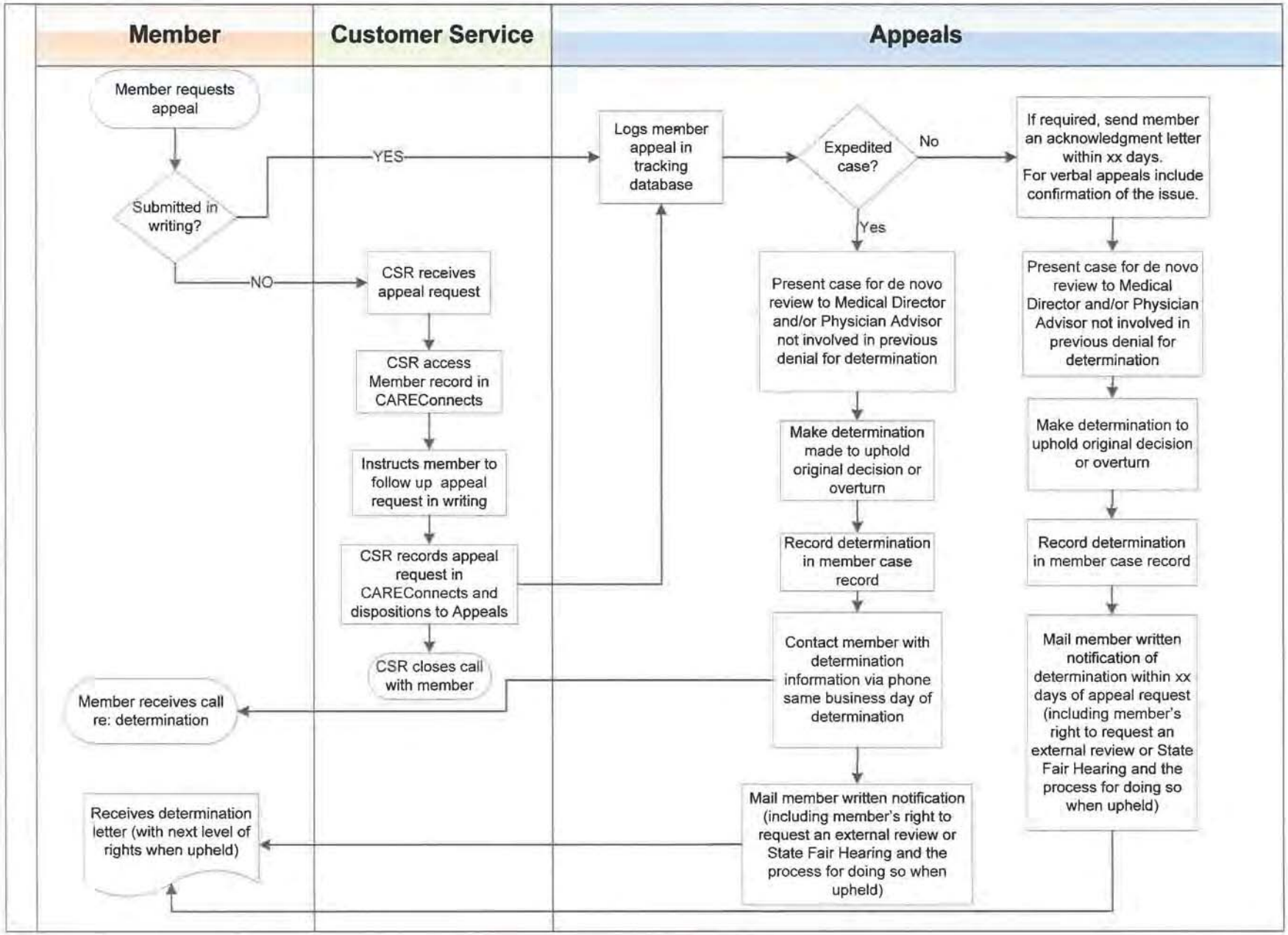


Issued: 01/04/07
Revised: 10/01/15

Attachment 36b_Pharmacy Appeals Process Flow



MEMBER CLINICAL APPEALS FLOW CHART



SECTION IV.H GRIEVANCES AND APPEALS

37. Describe the approach the MCO will take to provide members with grievance, appeal, and State fair hearing information. Address how the MCO 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 pages)*

WELLCARE'S APPROACH TO HELPING MEMBERS UNDERSTAND AND EXERCISE THEIR GRIEVANCE, APPEAL, AND STATE FAIR HEARING RIGHTS

Having focused on members who receive health care coverage through government programs for more than 20 years, WellCare knows that effective communication requires a multi-faceted approach tailored to the unique needs of the diverse populations we serve. After meeting with individuals in both the family and aged, blind and disabled programs in Nebraska, it became clear to us that traditional communication methods alone will not be sufficient. For example, one individual with whom we met, a Native American, dually-eligible for Medicare and Medicaid, told us that she had been denied access to a provider because she could not afford the $50 they wanted to collect from her as a "co-pay." When we asked if she knew she could call her Medicaid or Medicare plan to file a complaint, she said she had "no idea". While she received member materials, they were too daunting to read so she had not read them.

Our Strategies Feature Best Practices Tailored to Meet the Needs of Nebraskans

Because of experiences like this one, WellCare will seek to partner with stakeholders in Nebraska to develop the right communication strategies for Nebraskans. Strategies we have successfully used include:

- Adding specific and simple language as part of a keepsake item, such as a magnet, in a welcome packet that lets members know they can easily file a grievance or appeal
- Leveraging our large network of social service agencies and partners (as identified in our proprietary Navigator Database of social safety net programs and all of the databases within the CommUnity Command Center) to spread critical coverage information, including information on how to file a grievance or appeal
- Partnering with providers to help members navigate the processes, particularly for appeals where providers can advocate on behalf of the member

Additionally, we will use standard managed care approaches to inform members of appeal and grievance rights and procedures including posting detailed information online, including detailed information in the member handbook, and featuring information in our quarterly member newsletters. Among the important information we will feature in the handbook will be information about grievances, appeals and State fair hearings, as described in 42 CFR 438.400-424 and section IV. F. 5. F. xxvii of the RFP. These approaches will be tailored to meet the cultural, linguistic and socioeconomic needs of our members.

Making it Easy for Members to Exercise Their Rights

Our grievance and appeals submission processes are designed to make it easy for members to initiate grievances and appeals. We offer members the opportunity to submit a grievance or request for appeal through our website in addition to the standard submission channels of postal mail, fax, and telephone.

In addition to our main office in Lincoln, WellCare will also have Welcome Centers in Omaha, Kearney, Scottsbluff, and Norfolk. These offices will be staffed by a team of specialists who will provide local access to service and support, including assistance with grievances and appeals, for our members, providers and community partners. In addition to providing general information about and assistance with grievances and appeals, these associates will be able to receive members' grievances and appeals for those who prefer to discuss their concerns face-to-face or choose to hand-deliver their written request to WellCare. All associates who may interact with Nebraska members will be trained on recognizing a

grievance and assisting members with initiating the process. Our member services associates are trained and have job aids to guide them in informing members about their rights and the policies and processes related to grievances, appeals (including expedited appeals), and State fair hearings, including the member's exhausting internal appeal methods prior to appealing to the State.

WellCare also includes information about members' rights to file a grievance, request an appeal, and request a State fair hearing in the initial notice of adverse action, notice of appeal decision, and grievance closure letters. These communications include simple, easy-to-understand instructions for how to do so.

We also communicate with providers about member grievance and appeal rights so they are knowledgeable about the process and can assist members accordingly. This includes important information about the member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending. This information is communicated with providers in the provider manual, through our quarterly provider newsletter, and our provider portal as well as in the notice of action and notice of appeal decision letters.

Communicating with associations and groups of providers is an additional component of this process. We will disseminate our grievance and appeals process through groups like the Nebraska Health Care Association, Nebraska Association of Behavioral Health Organizations, Nebraska Medical Association, Nebraska Hospital Association, 638 Tribal Clinics/Indian Health and the Health Center Association of Nebraska. We have already begun a dialogue with these groups and will leverage our relationship with them to help inform how we best communicate with individual providers around grievances and appeals.

Helping When A Member's Primary Language Is Not English or They Have Visual Impairments

WellCare has extensive experience serving members whose primary language is not English or who have visual impairments. We currently communicate with Medicaid members throughout the country in our affiliate plans in a variety languages and formats including Spanish, Chinese, Russian, Korean, Vietnamese, Tagalog, large print, Braille, and audio. For Nebraska members, we will make the member handbook available in Spanish and alternative formats (i.e., audio). Our website is standardly available in Spanish and is compliant with Section 508 of the Rehabilitation Act of 1973, as amended, ensuring access for members who are visually impaired. In addition, all English grievance and appeal correspondence, including our acknowledgement letters and closure letters, prominently feature information about how to request the correspondence in other languages or formats. Member services associates help members with verbal translation if urgent. Otherwise, our member service and local staff can request the correspondence be translated at no cost to the member and mailed to the member in his/her language or format of choice. In instances where we know in advance that the member needs an alternative language, such as Spanish, we proactively translate the correspondence and mail it to the member.

WellCare's Special Handling to Assist Members in Filing Grievances and Appeals

We encourage members and their families to be actively involved in the grievance and appeal process. Our acknowledgement letters advise members that they may present evidence and allegations of fact or law in person as well as in writing. Additionally, we make accommodations to assist members who may have impaired hearing, impaired vision, or speak a language other than English with filing an appeal or grievance (i.e., completing forms, taking procedural steps). This includes, but is not limited to, providing interpreter services at no cost to the member and toll-free numbers that have adequate TTD and interpreter capability. Members are also instructed of their right to examine the case file, including medical records and any other material to be considered, at any time before and during the process. Our member service, appeals, and grievance associates provide members with individualized support to help them navigate the grievance and appeal process.

IV.I Provider Network Requirements

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

38. Describe the MCO'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 IV.I.

Describe the method the MCO 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 behavioral health providers.
- Inclusion of high volume specialists.
- Inclusion of FQHCs and RHCs.
- Inclusion of urgent care centers.
- Inclusion of pharmacies.
- Inclusion of hospitals.

(Page limit 6 pages, excluding plan for developing an adequate network)

BUILDING A HIGH QUALITY PROVIDER NETWORK: WELLCARE'S OVERVIEW AND EXPERIENCE

WellCare embraces the fundamental imperative that ease of access to integrated high quality health care services is crucial to member health, wellness and satisfaction. We have extensive experience in the development and management of diverse and comprehensive provider networks. Our current networks deliver services to 3.8 million Medicaid, Medicare Advantage and Medicare Part D members through more than 170,000 contracted health care providers and 70,000 contracted pharmacies. This broad experience, built through our network development approach and policies, will ensure that covered services are available to Heritage Health members from a comprehensive network of providers.

In recognition of the impact of social determinates on a member's health and wellness, WellCare thinks of providers broadly to include social services. As part of our community engagement strategy we develop and maintain a state-specific inventory of community providers and programs which we call our social service network. For Nebraska, we have identified more than 5,000 local and national organizations to augment our existing catalog of 110,000 partners in all 50 states.

PROVIDER NETWORK OUTREACH APPROACH AND RECRUITMENT STRATEGY

Our recruitment strategy focuses on the development of a broad-based, integrated network that is well positioned to deliver the full array of covered benefits and services to our members including children in foster care and members with special health care needs. As part of our network development strategy we recognize the need to enhance access to behavioral health services by building a stronger behavioral health network than currently exists in Nebraska. We will also build on the ground-breaking efforts Nebraska has undertaken to adopt patient-centered medical homes and the current pilots for integration to support the rise of behavioral health homes (also referred to as integrated health homes).

In developing our network, we first and foremost understand that the delivery of health care is local. As demonstrated by our Nebraska provider engagement activity to date (described below), we will frequently communicate with and listen to the provider community as we build our Nebraska network. We have found that there is no better teacher about local health care delivery than the provider community itself.

We employ a five-phase approach to network development and management, moving from early analysis of the market and membership needs to targeted recruitment, contracting, training and retention activities,

as detailed in our network development plan. See **Figure 1** for our network development and contracting continuum.

Figure 1

WellCare recruitment resources and tools will be located in the Nebraska marketplace. We will deploy a large team of local resources to support face-to-face encounters with institutions, physicians and other providers. These resources are supplemented by our national network development team which includes specialists in institutional, group practice, and ancillary contracting and legal experts in contract development. Our pharmacy benefit manager (PBM) also brings experienced staff to the network development process. Our network recruitment center will be staffed by a team of contract specialists who actively collect executed contracts, process mailings, answer inbound calls, make outbound follow up calls, and assist providers with all aspects of contracting and credentialing.

Track Record of Building Networks in Other States

WellCare has extensive experience in the development of broad, integrated high-performing provider networks in both long and shorter-term implementation windows. Our fundamental operating principles are based on effective, trust-based relationships, so whenever we initiate development of a new provider network, we first begin with relationship development. From there, we are well-positioned to begin more active contract negotiations.

For example, upon being awarded a contract for Kentucky's Medicaid managed care program in late April 2011, we had roughly 90 days to build a fully accessible provider network in time for readiness review and a September 1st implementation. Because our Kentucky leadership had for several months been actively engaged in relationship building with key health systems across the Commonwealth, we were prepared to address and resolve any barriers to contract negotiation right away. Our success in launching a strong provider network in Kentucky contributed to a significant surge in member choice rates in the first quarter of 2011, continuing through 2012.

Nebraska Provider Engagement

For more than a year, we have deployed WellCare leaders to meet with key stakeholders across Nebraska to gain an understanding of issues related to the delivery of health care in Nebraska, including meetings with Nebraska Hospital Association, Nebraska Medical Association, Leading Age Nebraska, Nebraska Health Care Association, Nebraska Association of Behavioral Health Organizations Nebraska

Pharmacists Association, Health Center Association of Nebraska, Children and Family Coalition of Nebraska, Southeast Regional Provider Association ACO and tribal clinic/Indian Health Services representatives. We researched patterns of care and current gaps in care and built relationships with key providers and advocacy groups. We gathered input from the provider community on partnerships and also conducted blinded focus groups with members from many different populations including individuals with disabilities and their caregivers, children in the foster care system and children who have aged out, and low income families. We will build on this knowledge of the Nebraska delivery system as we develop our Nebraska network. The feedback we received accomplished multiple goals including:

- Helping guide the WellCare care model to best utilize existing innovation within the state
- Defining current gaps and challenges for providers that WellCare can focus on solving at launch
- Creating communication channels with providers to help maximize their success during the transition
- Establishing a network of social support organizations

Network Development Plan and Provider Contract Template

Our plan to develop an adequate provider network is in **Attachment 38a_Network Development Plan.** Our provider contract template is in **Attachment 38b_Provider Contract Template.**

METHODS TO ASSESS AND ENSURE NETWORK STANDARDS ARE MET

WellCare will provide available, accessible and adequate numbers of high-performing providers for the provision of covered services. Our goal is to meet and exceed the appointment availability and geographic access in Attachment 39 as well as Section IV.I requirements. In establishing and maintaining our provider networks, we consider the anticipated enrollment, expected utilization of services, the numbers and types of providers required to furnish services, the numbers of providers who are not accepting new patients, the geographic location of providers and members, and the services necessary to support our members with special health care needs. See **Figure 2** for a summary of our network development standards.

Figure 2

WELLCARE NEBRASKA NETWORK DEVELOPMENT APPOINTMENT AVAILABILITY ACCESS STANDARDS	
Provider Type	**Standard**
Emergency Services	Available immediately upon presentation 24/7. Emergent behavioral health needs referred within one hour or two hours in designated rural areas
Urgent care	Same day by PCP or as arranged by MCO
Non-urgent, sick care	Within 72 hours or sooner if the member's medical condition deteriorates
Family planning	Within 7 calendar days
Non-urgent, preventive	Within 4 weeks
PCPs	1 physician practice, office hours of at least 20 hours a week 2 or more physician practice, office hours of at least 30 hours a week
High volume specialists*	Routine: 30 calendar days of referral
Other specialists	Consultation available within 1 month of referral or as clinically indicated
Laboratory and x-ray	Routine: 3 weeks; Urgent: 48 hours (or as clinically indicated)
Maternity care	1st trimester: 14 calendar days; 2nd trimester: 7 calendar days; 3rd trimester: 3 calendar days; High-risk: 3 calendar days of identification

WellCare Nebraska Network Development Geographic Access Standards	
Provider Type	**Standard**
PCPs	2 PCPs in 30 miles urban; 1 PCP in 45 miles rural; 1 PCP in 60 miles frontier PCPs include physicians specializing in general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology (OB/GYN); advanced practice nurses and physician assistants when practicing within the scope of their license
Behavioral health inpatient and residential	Rural and frontier: Sufficient locations to allow members to travel and return home within a single day or alternative plans for accessing comparable levels of care if no inpatient available within that standard
Behavioral health outpatient	Urban: Adequate choice with 30 miles Rural: Minimum of 2 providers within 45 miles Frontier: Minimum of 2 providers within 60 miles Rural and Frontier: Use of telehealth if no providers in county
High volume specialists*	1 provider within 90 miles
Federally qualified health centers (FQHCs) and rural health clinics (RHCs)	Contract with all FQHCs and RHCs in Nebraska Notify Division of Medicaid and Long-Term Care (MLTC) if contract cannot be reached
Urgent care centers	Good faith effort to contract with urgent care centers in Nebraska Maximize availability of urgent care services to members, maintain documentation
Pharmacists	Urban: 1 retail pharmacy within 5 miles of 90% of members Rural: 1 retail pharmacy within 15 miles of 70% of members Frontier: 1 retail pharmacy within 60 miles of 70% of members
Hospitals	Contract with a sufficient number of hospitals to ensure that transport time will not exceed 30 minutes, except in rural areas where access time may be greater Critical access hospitals as defined by Attachment 16, other Nebraska and contiguous hospitals
Indian Health Services/Tribal 638/Urban Indian Health (I/T/U)	Extend contracts to all Sufficient number to ensure timely access to services for American Indian members
Contiguous states	Extend contracts to providers in contiguous states to address local referral patterns
**Includes cardiology, neurology, hematology/oncology, OB/GYNs and orthopedics specialties*	

Geographic Distance

We monitor geographical access between members and our provider network on a monthly, quarterly and ad hoc basis using Optum GeoAccess® GeoNetworks® software. Ongoing monitoring and trending of providers' member panel capacity is also analyzed. GeoAccess software is the industry standard to analyze and monitor potential provider network gaps. A large provider group or high volume specialist type or facility leaving our network or an anticipated change in population or covered services may trigger an ad hoc GeoAccess analysis.

GeoAccess software allows us to comprehensively monitor our network to maintain and exceed time and distance standards. Examples of reports produced for monitoring network adequacy include:

- **GeoAccess Reports**: Displays network adequacy by region, county and provider specialty type including detailed listing by specialty combination showing number of members to total number of providers. These reports will be run quarterly or on an ad-hoc basis

- **Exception History Log (EHL):** Records network gaps, current patterns of care and a narrative justification with steps to remedy for each network deficiency identified in GeoAccess
- **Compliance and Expansion Maps:** Real-time statistical analysis software maps that allow network management users to assess provider gaps and drill-down to investigate identified deficiencies
- **Access Compliance Snapshot:** A drillable GeoAccess dashboard report of the provider network specialties by county, run monthly. Each report is validated and then analyzed for network trends
- **Zip Code Analysis for Members without Access:** An analysis of members without access to specific specialties at the zip code level

To ensure specialist access, we regularly perform analysis of high volume specialists accepting new and existing members to determine if we meet the required distance and drive time access standards. High volume specialists will include those specialties identified in Attachment 39 as well as those identified annually through claims utilization data. The specialty types will be chosen based on the highest claim count within an annual reporting period. Our specialist analysis affords the opportunity to develop targeted recruitment opportunities to ensure necessary provider specialties are accessible to the members we serve. This analysis looks at the remaining providers of the same specialty type(s) to ensure that no access gaps have been created.

Monitoring Appointment Access

We monitor the timeliness of appointment access within our network through a variety of tools including appointment accessibility surveys, member grievances and provider complaints, member services and member engagement associates, member and provider satisfaction surveys, closed panel reports, out of network provider data, provider efficiency reports, and HEDIS results. We require all providers offer hours of operation that are no less than those offered to commercial or fee-for-service patients.

- **Appointment Accessibility Surveys:** We conduct quarterly telephone surveys to assess appointment availability, appointment wait time, and after-hours coverage. We re-audit any providers who fall short of standards and follow up with a corrective action plan as needed.
- **Member Grievances and Provider Complaints:** We review member grievances as well as provider complaints to monitor access to care. Our member services representatives review, log, and categorize grievances and complaints by cause, disposition and type for review and follow-up.
- **Member Services and Care Managers:** These associates work directly with members to monitor access and availability and assure members receive services in a timely manner. Our associates make outbound calls to members with identified care gaps to set provider appointments and close care gaps. They also help our members who are having difficulty obtaining services in a timely manner.
- **Member and Provider Satisfaction Surveys:** Our annual surveys include key questions about the quality and adequacy of our provider network. We review the results of the survey to identify areas of opportunities for additional contracting as well as service improvements.
- **Closed Panel Reports:** Monthly closed panel reports are reviewed to identify providers who recently closed panels. Outreach is made to each provider in an attempt to have them re-open their panel. Closed panel percentages are reviewed by specialty to determine if additional providers are needed.
- **Out-of-Network Paid Claims:** We monitor out-of-network paid claim reports to identify providers that are currently not contracted with WellCare and target recruitment activities.

Using Local Community Knowledge to Continuously Fill Network Gaps

Our provider services representatives, care managers, clinical practice advisors, and member outreach associates are in the field daily working with members, families, providers and community-based organizations who are a valuable source of feedback concerning needs and opportunities to improve our members' access to covered services. Our provider services associates also meet regularly with providers in their region and initiate recruitment activities when they hear of a new provider moving to the area or

when a network provider contacts them about an out of network referral.

Promoting Cultural Competency Standards

We applaud Nebraska's efforts to promote the delivery of services in manner that is respectful of culture, language and heritage, and WellCare's proven experience with a broad array of diverse populations will add significant value to these efforts. We recognize that Nebraska has very specific regional needs and we will constantly strive to meet those needs by recruiting providers that can meet linguistic, cultural and social needs. While Latinos constitute 9.9 percent of the state's total population, according to the U.S, Bureau of the Census, a significantly higher penetration exists in some counties such as Colfax, Dakota, Dawson and Hall.

Cultural Sensitivity

Our Hawaii Medicaid plan included a native Hawaiian healer in a member's service plan because the member did not fully trust Western medicine.

We currently administer Medicaid programs in Florida, New York and Hawaii, three of the most culturally diverse states of the country. We will draw on that broad experience as we build our plan to deliver Nebraska services in a culturally competent manner. Our cultural competence strategy includes:

- Recruitment of a diverse array of providers
- Cultural competency training as part of the provider onboarding process and annual cultural competency training for all WellCare associates
- A yearly "cultural needs" assessment to assess performance, identify opportunities for improvement and actions to improve
- Monitoring physical access, accommodations, and accessible equipment for our members with physical, developmental, or mental disabilities
- Providing onsite sign language and oral interpretation service in provider offices at no charge to the provider or the member

When a specific cultural need is identified our provider services team will implement targeted recruitment of providers speaking that language or representing that culture in the geographic region.

Monitoring After-Hours Access Standards

PCPs are required to maintain 24-hour on-call coverage in accordance with WellCare standards. We will also offer non-emergent after-hours services through a network of urgent care centers and our 24/7 nurse line. Our patient-centered medical home (PCMH) standards include the provision for on-call access 24/7 and extended hours. Urgent care will be available the same day by the PCP or through other network providers such as urgent care centers.

Inclusion of Various Provider Types

As detailed in our network development standards above and the attached network development plan, WellCare will recruit a broad range of provider types including PCPs, behavioral health providers, specialists and high volume specialists, FQHCs, RHCs, Indian Health Service/Tribal 838 Clinics/Urban Indian (U/T/I) providers, urgent care centers, pharmacies, and hospitals. We will extend offers to contract to providers currently providing physical, behavioral health and pharmacy service to Nebraska Medicaid members and we will comply with all requirements of Section IV.I of this Request for Proposal (RFP) as we recruit providers. We will measure our network against our network development plan and standards which include geographic and appointment access, cultural competency and after-hour access. We currently offer Medicare Part D in Nebraska and have a pharmacy network of 489 pharmacies. This includes chains such as Wal-Mart, Walgreens, Hy-Vee, Shopko and CVS as well as many independent chains and independent community pharmacies. Any willing pharmacy that will accept the terms and conditions of the contract and meet credentialing requirements is eligible to be in the network.

WellCare
Health Plans

WellCare of Nebraska Network Development Plan

SECTION 1: GOALS AND STRATEGY OF NETWORK DEVELOPMENT

WellCare's extensive experience with the development of high-performing provider networks for government-sponsored healthcare programs provides us with the needed background and understanding of the specific health, geographic, cultural needs and preferences of the Nebraska Medicaid population that we will serve. Our network development and engagement strategy makes covered services available to the members of the Heritage Health program, through a committed network of primary care providers (PCPs), specialists, hospitals, Indian health services/tribal 638/urban Indian health (I/T/U) providers, urgent care facilities, federally qualified health centers (FQHCs), rural health clinics (RHCs), public health facilities, allied health care professionals, ancillary providers, behavioral health providers, and pharmacies.

The goal and approach of our network development strategy is to meet our members' needs by partnering with a diverse network of providers that represent a range of specialties and services and bring the most value to our members within each geographic region.

For over a year we have deployed WellCare leaders to meet with key stakeholders across Nebraska, laying the groundwork to prepare for network development in all areas of the state. We have met with hospitals, physicians, behavioral health specialists and social safety net providers. We have also focused on engaging with FQHCs, RHCs, and the state's medical, hospital, and health care associations because safety providers and the affiliations that currently exist are critical to building a comprehensive system of care to address Nebraska's needs. Our association meetings included meetings with Nebraska Hospital Association, Nebraska Medical Association, Leading Edge Nebraska, Nebraska Health Care Association, Nebraska Pharmacists Association, Health Care Association of Nebraska, Children and Family Coalition of Nebraska, Southeast Regional Provider Association ACO and tribal representatives. These efforts ensure that WellCare is prepared to fully execute our network development strategy to meet the state's expectations and do so by meeting the specific needs and challenges of local areas in Nebraska through the information gathered and relationships WellCare has built. WellCare is fully prepared to begin executing on our network development plan upon contract award.

As an example of our track record in building effective provider networks, upon being awarded a contract for Kentucky's Medicaid managed care program in late April 2011, we were required to build a fully accessible provider network in roughly ninety days in preparation for readiness review and a September 2011 implementation. Because WellCare had been actively engaged in building relationships with key providers and health systems for several months prior to being awarded the contract, as we have done in Nebraska, we were prepared to effectively execute on our network development strategy. Our success in launching a strong provider network in Kentucky contributed to supporting the state achieve its goal of implementing its program on schedule while ensuring that members received adequate access to services.

SECTION 2: Development of Network

WellCare of Nebraska understands the network requirements of the Heritage Health program contract. WellCare has combined the requirements with the expected membership and conducted geo-analytics to determine the network targets. In developing our networks we apply the necessary resources to actively recruit and maintain a network that offers our members a broad array of high-performing providers who deliver the scope of preventive, primary and specialty services, along with behavioral, pharmacy, and social services and supports. Our fundamental network development strategy is to:

- Determine expected enrollment
- Accurately determine precise network requirements to meet time, distance and appointment availability standards

- Target providers critical to meeting those standards and providing a comprehensive scope of services
- Expand our core network to encompass as many qualified participants as possible allowing both member choice and increased access to care

We employ a five-phase approach to network development and management, moving from early analysis of the market and membership needs to targeted recruitment, contracting, training and retention activities as described our network development and contracting continuum.

Our expected member enrollment is outlined in the table below.

Rating Region 1 (East)	Rating Region 2 (West)	Total
58,325	17,834	76,159

By segmenting the marketplace, adding the required time and distance standards and the required and essential providers, then layering the expected utilization, a targeted list of providers was created for our network. The targets are as follows:

- Providers currently providing physical, behavioral health and pharmacy services to Nebraska Medicaid members will be extended offers to contract
- Two largest hospital systems in Nebraska along with critical access hospitals, as described in Attachment 16
- Three largest provider groups collectively with over 1000 physicians, 150 large provider groups and small and individual providers throughout the state
- Independent urgent care centers
- FQHCs and RHCs throughout the state
- The complete Magellan behavioral health network
- Major behavior health facilities across the state
- Advanced practice nurses and physician assistants throughout the state
- Any willing pharmacy that accepts the terms and conditions of the contract
- All I/T/U providers
- WellCare national ancillary targets such as vision providers
- Providers in contiguous states to address specialty shortages and local referral patterns

Execution of the Strategy and Tactics

WellCare recruitment resources and tools will be located in the Nebraska marketplace. WellCare will deploy a large team of local resources to support face-to-face encounters with institutions, physicians and other providers. These resources will be supplemented by our national network development team which includes specialists in institutional, group practice, and ancillary contracting and legal experts in contract development. Our pharmacy benefit manager (PBM) also brings experienced staff to the network development process. Our network recruitment center will be staffed by a team of contract specialists who actively collect executed contracts, process mailings, answer inbound calls, make outbound follow up calls, gather and record required documentation, and assist providers with all aspects of contracting and credentialing.

We review and monitor daily and weekly target reports to determine the completion of the network and to identify necessary network adjustments.

WellCare Health Plans

Key Network Development Plan Activities & Milestones

WELLCARE OF NEBRASKA NETWORK DEVELOPMENT PLAN	
Month	**Goals and Tasks**
August 2015	➢ Research current delivery systems ➢ Identify key provider types for eligible populations ➢ Initiate relationships with key systems
November 2015	➢ Research patterns of care and current gap analysis; what populations are underserved and why? ➢ Build out relationships with key providers, professional societies and advocacy groups ➢ Initiate development of provider list based on specialty types and network access parameters
December 2015	➢ Develop Letter of Intent for interim use, if appropriate ➢ Conduct analysis of competitor networks and waiver provider network ➢ Analyze state fee-for-service file ➢ Obtain advocate feedback ➢ Review providers that have initiated a request to participate in the network ➢ Further develop provider list, identifying PCPs, behavioral health providers, specialists, FQHCs, RHCs, urgent care centers, laboratories, pharmacies, I/T/U providers, hospitals and other provider types for recruitment ➢ Preparation work on contract templates for PCP, specialty, ancillary and provider agreements ➢ Professional society visits, gather input from provider community on transformative partnerships. What has not worked and why
February 2016	➢ Provider Mailing #1: Distribute corporate overview to key health systems and provider groups ➢ Establish web and telephonic methods for provider questions and answers on network participation ➢ Develop network access strategies for rural/frontier/underserved areas. Examples might include telehealth, mobile delivery, clinic incentives, etc. ➢ Build out range of reimbursement options for fee for service, shared savings and value-based purchasing
March 2016	➢ Ancillary contract negotiation underway with national vendors (vision, 24/7 nurse line) ➢ Provider Mailing #2: Offer to contract letter to all providers on current list, including instructions on how to request a contract ➢ Create and secure approval for a workflow flyer to accompany all provider contracts, demonstrating the steps for provider credentialing and configuration ➢ Create email inbox for provider contract requests and/or questions and answers, establish frequently asked question workflow and publication method
April 2016	Initiate negotiations/redlines with key hospitals, facilities, IPAs and complex providers Inventory management established for incoming provider contracts, including data integrity audit Provider Mailing #3: Filter mailing list against in-house inventory, then drop PCP/specialist contracts via USPS Round One: Regional Provider Information Summits –Informational and open question and answer (Q&A) forums for all Nebraska and border-state providers
May 2016	➢ Post Nebraska Provider Q&A link on WellCare of Nebraska home page ➢ Filter mailing list against in-house inventory, then drop PCP/specialist contracts via USPS

	➢ Ground game: Initiate outbound call campaign to schedule network development visits and promote Q&A interface ➢ Round Two: Regional Provider Information Summits – Informational and open Q&A forums for all Nebraska and border-state providers
June 2016	➢ M-W-F Checkpoints: Weekly gap analysis review each Monday morning, with Wednesday p.m. and Friday p.m. progress reports ➢ All inbound contracts and credentialing applications audited for complete information (signatures, W9, etc.) before provider load form (PLF) created ➢ PLF exceptions for missing/inaccurate information under a 72-hour turnaround. Flat file load template disseminated as appropriate ➢ County-by-county blitz visits to non-respondents, daily debrief and determination of barriers and remediation strategies
September 2016	➢ Access-compliant network contracts in house and in credentialing/configuration workflow for directory production and January 1, 2017 implementation. ➢ Submit our provider network to MLTC at least 90 calendar days prior to contract start date.
October 2016	➢ Submit documentation to MLTC 45 days prior to implementation on any services or provider types that do not meet MLTC standards due to lack of providers in the area.

In developing our network we will

- Offer female members direct access to a woman's health specialist for routine and preventive care
- Offer direct access to specialists in special situations including members who meet special health care needs criteria
- Ensure a provider network that includes sufficient numbers of providers with experience and expertise in:
  - Co-occurring mental health and substance use disorders/developmental disabilities
  - Serious and persistent mental illness
  - Severe emotional disturbance among children and adolescents
  - Sex-offending behaviors, eating disorders, co-occurring serious mental illness, and common chronic physical illness
- Contract with providers who demonstrate a commitment to the behavioral health principles of care defined in the Request for Proposal (RFP) Section IV.L, Care Management, including rehabilitation and recovery and focus on recovery-oriented, trauma informed services and trauma-specific treatment programs
- Cooperate with the Department of Health and Human Services Division of Behavioral Health and state behavioral health regions as we establish our network

SECTION 3: Ongoing Network Management – Including network adequacy, identifying and resolving barriers and network gaps

Once the initial network is completed, assessing the adequacy of our provider network is a continuous process. The staff uses numerous tools and data sets to identify potential gaps and the need for expansion activities. Our ongoing activities allow us to identify opportunities as they arise to proactively respond with enhancement strategies. A key element to our overall Network Development Plan is the ongoing management and assessment of our network of providers at a regional and county level.

The comprehensive, ongoing monitoring and development of our provider network allows us to maintain and work to exceed member satisfaction, access to care and to comply with the Heritage Health program requirements. Analysis includes:

- **GeoAccess Reports:** On a monthly basis, these reports evaluate that time and distance standards are

being adequately met at the provider level to meet the needs of members in each county. GeoAccess results are the key element reviewed at a quarterly meeting and an actionable plan results from the analysis.

- **Quality Dashboard:** On a monthly basis, we measure HEDIS results at the provider or group level. Quality trends and care gap quality improvement data is shared with providers during regularly scheduled meetings with providers, our field quality team and our provider services specialists.
- **Provider Efficiency:** On a monthly basis, we will review member cost of care with our key provider groups to identify providers with utilization levels that are outside of a normal range of bell curve utilization. We also review key statistics at a provider level, including their use of electronic funds transfer and electronic data interchange for administrative efficiency.
- **Appointment Availability:** When recruiting providers for our network, we validate that they have capacity and are able to make appointment times available to members on a timely basis. We engage a third-party vendor to conduct an annual study of appointment availability using a statistically valid sample of PCP and specialist practices. Average appointment times are evaluated to ensure that offices are in compliance with the access standards as defined in the contract.
- **Out Of Network Monitoring:** On a monthly basis, out-of-network utilization reports are reviewed by health services and the network teams.
- **Open/Closed Panels:** Primary care closed panels are measured and reported to provider services.

Our network development standards are detailed in the table below.

WELLCARE NEBRASKA NETWORK DEVELOPMENT APPOINTMENT AVAILABILITY ACCESS STANDARDS	
Provider Type	**Standard**
Emergency Services	Available immediately upon presentation 24/7. Emergent behavioral health needs referred within one hour or two hours in designated rural areas
Urgent care	Same day by PCP or as arranged by MCO
Non-urgent, sick care	Within 72 hours or sooner if the member's medical condition deteriorates
Family planning	Within 7 calendar days
Non-urgent, preventive	Within 4 weeks
PCPs	1 physician practice, office hours of at least 20 hours a week 2 or more physician practice, office hours of at least 30 hours a week
High volume specialists*	Routine: 30 calendar days of referral
Other specialists	Consultation available within 1 month of referral or as clinically indicated
Laboratory and x-ray	Routine: 3 weeks Urgent: 48 hours (or as clinically indicated)
Maternity care	1st trimester: 14 calendar days; 2nd trimester: 7 calendar days; 3rd trimester: 3 calendar days; High-risk: 3 calendar days of identification
WELLCARE NEBRASKA NETWORK DEVELOPMENT GEOGRAPHIC ACCESS STANDARDS	
Provider Type	**Standard**
PCPs	2 PCPs in 30 miles urban; 1 PCP in 45 miles rural; 1 PCP in 60 miles frontier PCPs include: - Physicians specializing in general practice, family practice, internal medicine, pediatrics

	or obstetrics/gynecology (OB/GYN) ➢ Advanced practice nurses and physician assistants when practicing within the scope and requirements of their license
Behavioral health inpatient and residential	Rural and frontier: Sufficient locations to allow members to travel and return home within a single day or alternative plans for accessing comparable levels of care if no inpatient available within that standard
Behavioral health outpatient	Urban: Adequate choice with 30 miles Rural: Minimum of 2 providers within 45 miles Frontier: Minimum of 2 providers within 60 miles Rural and Frontier: Use of telehealth if no providers in county
High volume specialists*	1 provider within 90 miles
FQHCs and RHCs	Contract with all FQHCs and RHCs in Nebraska Notify MLTC if contract cannot be reached
Urgent care centers	Good faith effort to contract with urgent care centers in Nebraska Maximize availability of urgent care services to members Maintain documentation detailing the efforts
Pharmacists	Urban: 1 retail pharmacy within 5 miles of 90% of members Rural: 1 retail pharmacy within 15 miles of 70% of members Frontier: 1 retail pharmacy within 60 miles of 70% of members
Hospitals	Contract with a sufficient number of hospitals to ensure that transport time will not exceed 30 minutes, except in rural areas where access time may be greater Critical access hospitals as defined by Attachment 16, other Nebraska and contiguous hospitals
Indian Health Services/Tribal 638/Urban Indian Health	Extend contracts to all Sufficient number to ensure timely access to services for American Indian members
Contiguous states	Extend contracts to providers in contiguous states to address local referral patterns

*Includes cardiology, neurology, hematology/oncology, OB/GYNs and orthopedics specialties

In the event that we discover that there are gaps in the network or barriers to care that require network remediation, WellCare of Nebraska employs the following solutions:

- **Leverage Provider Partnerships:** Our network development team and provider services teams encourage partner network providers to extend hours and reach to expand access during initial contracting and ongoing conversations with the network.
- **Closed Panel Management:** The providers identified with closed panels are specifically contacted by provider services to determine if they are closed panel because their practice is at full capacity and are closed to all payers, or if there is an issue with WellCare that can be resolved.
- **Telehealth:** WellCare will partner with providers, groups of providers, and the Nebraska Statewide Telehealth Network (NSTN) to extend health care resources to those in need using video technology. NSTN is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, provider offices and rural health clinics. This includes clinical consultation, support groups, education and training and connectivity for administrative meetings among professionals.
- **Transportation:** Recognizing transportation as one of the biggest barriers to health care in Nebraska, we will facilitate coordination of transportation for members to improve access to care. We will use warm transfers and assist members in making appointments with the transportation vendor. In

addition, we track all referrals to non-benefited services including transportation.

- **Out-of-Network Utilization:** As needed, we will develop relationships with non-participating providers to allow us to work with them on a case-by-case basis to secure member access to the appropriate level of medically necessary care. Typically, we arrange care with out of network providers by executing single case agreements that authorize care for a specific member. In limited instances we will seek to establish a permanent non-participating agreement with high-impact providers who do not wish to contract. We will always seek to contract with any high-quality provider that has out of network utilization.

SECTION 4: Provider Training & Support

Initial and ongoing provider training and support is foundational to our network development and management plan, as well as provider retention. WellCare's provider services staff delivers training and answers provider questions related to training content. We employ a blended training delivery model that includes classroom, provider's office, web courses, & real-time interactive web meetings. The following provider training modules support compliance, improve provider performance and quality, and enhance provider satisfaction.

- How to register with our Provider Portal
- How to Request an Authorization
- How to File a Claim
- How to submit a corrected claim
- How to Submit Encounters when a service is rendered that is not tied to payment
- Understanding Explanation of Payments Documents and Files, using the Provider Portal
- Electronic Funds Transfer (EFT) and Electronic Remittance Advices for Claims Payments
- How to File an Appeal if a claim is denied , focusing on the process and timeframes
- Member Enrollment and Eligibility Verification
- Member Engagement Strategies
- Completing Health Risk Assessment and Comprehensive Assessments
- Benefits Overview
- Cultural /Linguistic/Social Needs of Members/Cultural Competency
- Heritage Health Program and Contract requirements
- EPSDT Requirements and Processes
- Identification & Reporting of Abuse, Neglect, and Exploitation of Children & Vulnerable Adults
- Education on Care Management/Disease Management/Wellness programs
- Utilization Management Criteria
- Complaints and Grievances
- Pharmacy Processes and Resources
- Health Information Exchange (HIE)/Electronic Health Record (EHR)
- HEDIS & Other Quality Goals & Tools
- Coding/Medical Records

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into by and between WellCare of Nebraska, Inc. ("**Health Plan**") and [Insert Name of Contracted Provider] ("**Contracted Provider**"). Health Plan and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

WHEREAS, Contracted Provider provides or arranges for the provision of health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

WHEREAS, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide or arrange for the provision of health care items and services to Health Plan's health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

NOW THEREFORE, the Parties agree as follows:

1. Construction.

1.1. The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2. The following rules of construction apply to this Agreement: (a) the word "**include**", "**including**" or a variant thereof shall be deemed to be without limitation; (b) the word "**or**" is not exclusive; (c) the word "**day**" means calendar day unless otherwise specified; (d) the term "**business day**" means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1. "**Affiliate**" means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity "**controls**" an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

2.2. "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government

Contract. Benefit Plans and their designs are subject to change periodically.

2.3. "**Carve Out Agreement**" means an agreement between Health Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for radiology, laboratory, dental, vision, or hearing services.

2.4. "**Clean Claim**" means a claim for Covered Services that is (i) received timely by Health Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

2.5. "**Credentialing Criteria**" means Health Plan's criteria for the credentialing or re-credentialing of Providers.

2.6. "**Covered Services**" means Medically Necessary health care items and services covered under a Benefit Plan.

2.7. "**DHHS**" means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services ("**CMS**") and its Office of Inspector General ("**OIG**").

2.8. "**Effective Date**" means the date this Agreement becomes effective as determined by Health Plan and set forth on the signature page of this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, the Effective Date is subject to Health Plan's completion of credentialing and determination that Contracted Provider meets the Credentialing Criteria.

2.9. "**Emergency Services**" shall be as defined in the applicable Program Attachment.

2.10. "**Encounter Data**" means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.11. "**Federal Health Care Program**" means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid, and CHIP.

2.12. "**Government Contract**" means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.13. "**Governmental Authority**" means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.14. "**Ineligible Person**" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the System for Award Management maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's

mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

2.15. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("**Medicare**"), XIX ("**Medicaid**") and XXI (State Children's Health Insurance Program or "**CHIP**"), (b) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.16. "**Medically Necessary**" or "**Medical Necessity**" shall be as defined in the applicable Program Attachment.

2.17. "**Member**" means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.18. "**Member Expenses**" means copayments, coinsurance, deductibles, or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.19. "**Non-Contracted Services**" means Covered Services that are (a) subject to Carve Out Agreements and not approved by Health Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

2.20. "**Overpayment**" means the payments a Provider receives from Health Plan or its Affiliates to which the Provider is not entitled, including payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to subcontracted Providers.

2.21. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.22. "**Principal**" means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.23. "**Program**" means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.24. "**Program Attachment**" means an attachment to this Agreement describing the terms of a Provider's participation in Health Plan's provider network for a Program.

2.25. "**Program Requirements**" means the requirements of Governmental Authorities

governing a Provider's participation in Health Plan's provider network and rendering Covered Services to Members pursuant to a Benefit Plan, including where applicable the requirements of a Government Contract, which include those terms set forth in a Program Attachment.

2.26. "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is employed, or directly or indirectly subcontracted by Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.27. "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides, WellCare Companion Guide, and educational materials setting forth Health Plan's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time. The Provider Manual is available on Health Plan's website.

2.28. "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2.29. "**WellCare**" means WellCare Health Plans, Inc., an Affiliate of Health Plan.

2.30. "**WellCare Companion Guide**" means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

3. Scope.

3.1. Non-Contracted Services are outside the scope of this Agreement.

3.2. Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member's medical condition or available treatment options.

3.3. This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4. Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5. Subject to Laws and Program Requirements, Health Plan reserves the right to approve any Provider's participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

4. Provider Responsibilities.

4.1. Principals. Contracted Provider shall comply with requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal Health Care Programs as described in section 1124 of the Social Security Act, 42 CFR part 420 subpart C (Program Integrity: Medicare) and 42 CFR part 455 subpart B (Program Integrity: Medicaid).

Contracted Provider represents that it has provided Health Plan with the information listed on the Attachment titled "Information for Contracted Provider / Principals" for itself and all of its Principals as of the Effective Date. Contracted Provider shall notify Health Plan of any change in the information within 30 days of such change.

4.2. Providers. Contracted Provider shall provide Health Plan with the information listed on the Attachment titled "Information for Providers" for itself and the Providers as of the Effective Date, in a form and format acceptable to Health Plan. Contracted Provider shall provide notice to Health Plan of any change in the information for itself and the Providers within 30 days of the change. When Contracted Provider terminates a Provider, other than for cause, Contracted Provider will give Health Plan at least 90 days prior written notice of the termination.

4.2.1. Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2. Subcontracted Providers. If Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers:

(a) Contracted Provider shall maintain and enforce written agreements with its subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of entire agreements between itself or other Providers and the subcontracted Providers. The compensation terms in such agreements may be redacted unless required by Governmental Authorities. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(b) Upon Health Plan's request, Contracted Provider shall provide Health Plan with a duly executed Opt In Agreement in the form set forth on the Attachment titled "Form of Opt-In Agreement" from each subcontracted Provider. Each executed Opt In Agreement shall be made a part of and incorporated into this Agreement, and Contracted Provider accepts the appointment in the Opt In Agreement to act on the subcontracted Provider's behalf. If Health Plan requests and does not receive a duly executed Opt In Agreement for a proposed subcontracted provider, Health Plan shall not approve the proposed subcontracted provider or its employed providers as Providers under this Agreement. Contracted Provider waives any non-compete provisions in its agreements with subcontracted Providers to the extent that, if enforced, would prohibit a subcontracted Provider from contracting directly with Health Plan pursuant to the Opt-In Agreement.

(c) Subcontracted Providers shall maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(d) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

4.2.3. Credentialing. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3. Covered Services. Providers shall provide Covered Services to Members, subject to and in accordance with the terms of this Agreement.

4.3.1. Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2. Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3. Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization.

4.3.4. Referrals. Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of Health Plan, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted by the Provider Manual. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5. Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Health Plan to determine if an item or service is a Covered Service.

4.3.6. Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

4.4. Claims and Encounter Data / EDI.

4.4.1. Clean Claims. Providers shall electronically prepare and submit Clean Claims to Health Plan within _____ days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2. Additional Reports. If Health Plan requests additional information, data, or reports from a Provider regarding Covered Services provided to Members for risk adjustment data validation or other administrative purposes, even if Health Plan has paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.3. NPI Numbers / Taxonomy Codes. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.4. Electronic Transaction Requirements. Provider shall submit all claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in accordance with the current HIPAA Administrative Simplification transaction standards and WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.5. EFT / Remittance Advice. If a Provider is able to accept payments and remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice no later than 60 days following Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.6. Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same

items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.7. Subrogation. Providers shall cooperate and assist Health Plan with its subrogation efforts.

4.4.8. No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

4.5. Member Protections.

4.5.1. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons (other than Health Plan) acting on the Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3. Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4. Except where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

4.5.5. Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6. Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of

material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7. Quality Improvement. Providers shall comply with Health Plan's quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality or outcome measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members.

4.8. Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, and (d) corrective action plans.

4.9. Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.10. Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

4.10.1. Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.10.2. Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.10.3. Compliance Program / Reporting. OIG publishes compliance program guidance for health care firms available at http://oig.hhs.gov/fraud/complianceguidance.asp. Contracted Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and to report to Health Plan any suspected fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with

such requirements.

4.10.4. Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.10.5. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("**FQHCs**") or rural health clinics ("**RHCs**") where applicable.

(c) If a Governmental Authority imposes a reduction to the Federal or State funds Health Plan receives under a Government Contract, Health Plan may adjust its payments to Provider by an equivalent or comparable amount. Such adjustment shall be effective concurrent with the effective dates such reductions are imposed upon Health Plan.

4.10.6. Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.10.7. Compliance Audit. Health Plan shall be entitled to audit Providers with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.10.8. Fines / Penalties. The following applies if Provider is capitated or Health Plan has delegated activities to Provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of Health Plan by Governmental Authorities caused by Provider's failure to comply with Laws or Program Requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

4.11. Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement. As required by Program Requirements, Providers shall meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all accreditations necessary to meet such conditions of participation.

4.12. Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.13. Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public (**"Proprietary Information"**). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.14. Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall notify Health Plan within five business days of Contracted Provider's knowledge, or when Contracted Provider should have known, of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are suspended, limited, revoked or terminated, (g) a Provider is under investigation for fraud or a felony, or (h) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

5.1. ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2. Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines,

and state specific regulations (collectively, "Coding Authorities"). These software programs may result in claim edits for specific procedure code combinations.

5.3. Compensation. Compensation shall be as set forth in Attachment C. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement. Items and services constituting "**never events**" as described in the Provider Manual shall not be paid. Health Plan shall not pay for Non-Contracted Services.

5.4. Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5. Overpayments. Overpayment recovery shall be in accordance with Health Plan's Provider Manual and Providers shall refund Overpayments to Health Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Health Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Health Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud.

5.5.1 Unless prohibited by Laws or Program Requirements, Contracted Provider, for itself and the Providers, authorizes Health Plan to offset Overpayments against any future payments due to Provider.

5.5.2 Except for offsets related to changes in Member eligibility, which shall not require notice prior to deducting Overpayments, Health Plan shall notify Providers that an offset against future payments will occur unless the Provider (a) refunds such amounts within the Notice Period, or (b) provides Health Plan with a written explanation of why the Overpayments should not be refunded along with any supporting documentation. If the Provider does not respond within the Notice Period, Health Plan shall deduct Overpayments from future payments.

5.5.3 If Provider disputes Overpayments within the Notice Period, Health Plan shall review the Provider's explanation and supporting documentation. Health Plan shall notify Provider of its decision to either uphold or overturn its initial determination that the payment at issue was an Overpayment. If Health Plan upholds its decision, the Overpayment will be offset against future payments unless prohibited by Law or Program Requirements.

5.6. Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7. Health Plan Designees. With regard to administering Benefit Plans, Health Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to

the same extent Provider is required to cooperate with Health Plan.

6. Records, Access & Audits.

6.1. Maintenance. Contracted Provider shall, and shall cause its Providers and subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Members, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, "**Records**"). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable), and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider's obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2. Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider, Providers, and their subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause Providers and its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within [three][five] business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, collect, compile, and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan.

6.3. The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

7.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least [90] [Hospital: 180] days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2. Termination.

7.2.1. Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan, or Covered Service, at any time for any reason or no reason upon [90] [Hospital: 180] days prior notice to the other. Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon [90] [Hospital: 180] days prior notice to Contracted Provider.

7.2.2. Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other

Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3. Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of Members, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) another Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) Health Plan reasonably determines or a Governmental Authority determines or advises that a Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim, (f) a Provider fails to meet Credentialing Criteria, (g) a Provider fails to maintain insurance as required by this Agreement, (h) a Provider undergoes a change of control that is not acceptable to Health Plan, or (i) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

7.2.4. Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5. Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

8. Dispute Resolution.

8.1. Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking

any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2. Except as prohibited by State Laws, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3. Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a "**Dispute Initiation Notice**") to the other providing a brief description of the nature of the dispute, explaining the initiating Party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "**Dispute Reply**") to the initiating Party providing a brief description of the receiving Party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4. Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in _____, _____. The arbitration shall be conducted through the American Arbitration Association ("**AAA**") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than $10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1. Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of _____, except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to

be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in _____, _____, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.2. Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.3. Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.4. Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.5. No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

9.6. No Offshore Contracting. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

9.7. The following applies to State plans: Contracted Provider shall not, and shall require Providers and their subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its Providers and their subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.8. Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile, or (e) regular U.S. mail, first-class postage prepaid, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery, except for regular U.S. mail, which shall be deemed delivered seven days after the date of mailing. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.9. Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements, and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements, or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements, or accreditation standards, and such amendment shall be effective upon receipt.

9.10. Amendment. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.11. Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

9.12. Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term "**assign**" or "**assignment**" includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party.

9.13. Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan's or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.14. Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.15. Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member's benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.16. Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.17. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.18. Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.19. Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.20. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.21. Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.22. Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.23. Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.24. Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.25. Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

9.25.1. The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.25.2. The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.25.3. This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.25.4. The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

The following Attachments are incorporated into and made a part of this Agreement:
Attachment A - Provider Specific Requirements/Covered Services/Information
Attachment B - Program Attachments
Attachment C - Compensation

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SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

WellCare of Nebraska, Inc.	**Insert Name of Contracted Provider**
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____
	TIN: _____

Health Plan Notice Address:	Contracted Provider Notice Address:
Street Address City, ST Zip ATTN: Network Management	Street Address City, ST Zip ATTN:
Fax: Email:	Fax: Email:

FOR HEALTH PLAN USE ONLY

Effective Date: _____

(To be completed by Health Plan following approval of Contracted Provider as a Health Plan participating provider, which approval is subject to credentialing but not limited thereto. Any attempt by Contracted Provider to fill in an effective date shall have no force or effect.)

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

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ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(PHYSICIAN/IPA/PHYSICIAN GROUP/NP/FQHC/RHC/BEHAVIORAL HEALTH SERVICES)

1. Additional Definitions.

   a. "**Assigned Member**" means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member's Primary Care Provider.

   b. "**Covering Provider**" means a Provider who provides health care items and services to another Provider's patients when the other Provider is not available.

   c. "**Nurse Practitioner**" means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.

   d. "**Physician**" means a Provider who is a doctor of medicine or osteopathy.

   e. "**Primary Care Provider**" means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.

   f. "**Primary Care Services**" means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.

   g. "**Specialty Provider**" means a Provider who provides Specialty Services.

   h. "**Specialty Services**" means health care items and services within the scope of a particular medical specialty.

2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.

3. If Contracted Provider employs or subcontracts with Providers to provide Covered Services, Contracted Provider shall be responsible to ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.

4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

   a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.

   b. The Provider shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

5. If a Provider provides or arranges for the provision of Specialty Services, the Provider shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.

6. Except for Emergency Services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.

7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(MEDICAL FACILITY)

Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are facility based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

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ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(ANCILLARY PROVIDER)

Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are ancillary health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

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ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(HOSPITAL)

1. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are hospital based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

2. Covered Services include professional services of hospital based physicians and their physician extenders.

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ATTACHMENT A-2
INFORMATION FOR CONTRACTED PROVIDER / PRINCIPALS

1. Contracted Provider is a:

   _____ Sole Proprietor
   _____ Corporation
   _____ Partnership
   _____ Limited Liability Company
   _____ Professional Association

2. The Principals of Contracted Provider are:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

ATTACHMENT A-3
INFORMATION FOR PROVIDERS

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person

ATTACHMENT A-4
FORM OF OPT IN AGREEMENT
(SUBCONTRACTED PROVIDER)

THIS OPT IN AGREEMENT ("**Opt In Agreement**") is made by and between Health Plan and the subcontracted Provider identified below ("**Subcontractor**").

WHEREAS, Health Plan and [Name of Contracted Provider] ("**Contracted Provider**") are Parties to the Participating Provider Agreement (as now or hereafter amended, the "**PPA**"); and

WHEREAS, Subcontractor is a subcontracted Provider under the PPA and will receive substantial benefits from the PPA;

NOW, THEREFORE, in consideration of those benefits and Health Plan entering into the PPA and this Opt In Agreement, Subcontractor agrees to the following:

1. Subcontractor has reviewed the PPA. The PPA is made a part of and incorporated into this Opt In Agreement. Capitalized terms not defined in this Opt In Agreement have the same definition as given in the PPA.

2. Subcontractor agrees to the terms and conditions of the PPA. Wherever in the PPA an action is required to be taken by Contracted Provider or a Provider, Subcontractor agrees to perform such action. Wherever in the PPA any representation or warranty is made by Contracted Provider or a Provider, Subcontractor agrees to comply with such representation or warranty.

3. Any obligation of Subcontractor in this Opt In Agreement or the PPA shall apply to Subcontractor's Providers to the same extent that it applies to Subcontractor. Subcontractor shall maintain and enforce internal policies and procedures or written agreements with its employed Providers that are consistent with and require adherence to the terms and conditions of this Opt In Agreement and the PPA. Subcontractor has the authority to bind its subcontracted Providers to this Opt In Agreement and PPA, and shall require the timely and faithful performance of this Opt In Agreement and the PPA by its subcontracted Providers.

4. Subcontractor hereby grants to Contracted Provider a power of attorney, coupled with an interest, to represent and bind Subcontractor in connection with all matters related to the PPA and this Opt In Agreement including granting any waivers of any of the terms of the PPA and this Opt In Agreement, and entering into any amendments or modifications of the PPA or this Opt In Agreement.

5. Subcontractor shall not assign any of its rights or delegate any of its duties or obligations under this Opt In Agreement or the PPA, in whole or in part, without the prior written consent of Health Plan.

6. If the PPA is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then Subcontractor: (a) for at least six months, shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of the PPA and this Opt In Agreement, (b) shall accept compensation from Health Plan for such Covered Services at the fee for service rates set forth in the PPA for the applicable Benefit Plans or, if the PPA does not include fee for service rates, at 100 percent of Health Plan's then current fee for service rates for the applicable Benefit Plans, and (c) after six months, may terminate its continuing participation under the PPA and this Opt-In Agreement upon 90 days prior notice to Health Plan.

7. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the PPA or

this Opt In Agreement, shall Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall be construed for the benefit of Members, (b) does not prohibit collection of Member Expenses where lawfully permitted or required, and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontractor and Members or persons acting on their behalf.

8. This Opt In Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Nebraska, except where Federal law applies, without regard to principles of conflict of laws.

9. Any dispute with respect to this Opt In Agreement or the PPA or Subcontractor's performance under this Opt In Agreement or PPA shall be subject to and resolved in accordance with the dispute resolution procedures in the PPA.

10. Subcontractor warrants and represents the Providers listed on the attached schedule are included in and subject to this Opt In Agreement and Subcontractor has the power and legal authority to, and has taken all necessary corporate or other action to, authorize the execution and delivery of this Opt In Agreement and the performance of its obligations hereunder and in accordance with the PPA.

The undersigned Subcontractor, with the intent to be legally bound, hereby agrees and accepts the terms of this Opt In Agreement by signing below.

Insert Name of Subcontractor

By: _____

Print Name: _____

Title: _____

Date: _____

ATTACHMENT B
PROGRAM ATTACHMENTS

(See following attachments)

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ATTACHMENT B-1
NEBRASKA MEDICAID AND CHIP
PROGRAMS ATTACHMENT

1. Participation in Nebraska Contract. Subject to and in accordance with the terms of the Agreement, including this Attachment, Contracted Provider agrees to participate in Health Plan's provider networks and render Covered Services to Members pursuant to the Benefit Plan offered or administered by Health Plan for the Programs in accordance with the Nebraska Contract.

2. Compensation. Compensation for Covered Services provided to Members of Benefit Plans under the Nebraska Contract is set forth in Attachment C.

3. Additional Definitions. The following definitions shall be incorporated into the Agreement. Capitalized terms used and not otherwise defined in this Agreement shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the Nebraska Contract or under Nebraska law:

   a. "**Department**" means the Nebraska Department of Health and Human Services.

   b. "**Emergency Medical Condition**" means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

   c. "**Emergency Services**" means covered inpatient and outpatient services that are as follows: (i) furnished by a provider that is qualified to furnish these services under Title 42 CFR; or (ii) needed to evaluate or stabilize an Emergency Medical Condition.

   d. **"MLTC"** means the **M**edicaid and **L**ong-**T**erm **C**are division of the Nebraska Department of Health and Human Services.

   e. "**Medically Necessary**" or "**Medical Necessity**" means those Covered Services and supplies that are, under the terms and conditions of the Nebraska Contract, determined through Health Plan utilization management to be: (1)Necessary to meet the basic health needs of the Member; (2)Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; (3)Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research or health care coverage organizations or governmental agencies; (4) Consistent with the diagnosis of the condition; (5) Required for means other than the convenience of the Member, the Member's physician or other provider; and (6) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency; (7) Of demonstrated value; and (8) No more intensive level of Covered Services than can be safely provided.

   f. "**Member**" means an individual or Covered Person enrolled in a Benefit Plan issued by Health Plan pursuant to the Nebraska Contract.

g. "**Nebraska Contract**" or "**NE Contract**" means the Contract between the DHHS and Health Plan, and includes, without limitation, the collective documentation, exhibits, schedules, amendments, and addendums containing the terms, conditions and requirements to implement the Benefit Plan such as the General Terms, Special Terms (SOW) and Special Contract Attachments. The Nebraska Contract is a Government Contract as defined in the Agreement.

h. "**Nebraska Medicaid Program**" **(NE Medicaid or Medicaid)** means health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers. NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services.

i. "**Nebraska Medical Assistance Program**" means Nebraska Medicaid

j. "**Patient-centered medical home**" **(PCMH)** means a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.

k. "**Post-Stabilization Care Services**" means, in accordance with 42 C.F.R. § 438.114(a), Covered Services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's stabilized condition.

l. "**State**" means the state of Nebraska or its designated regulatory agencies.

m. "**Subcontractor**" means any organization or person who provides a function or service for the Health Plan specifically related to securing or fulfilling the Health Plan's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

n. "**Value-Based Contract**" means payment and contractual arrangements with providers that include two (2) components: (i) provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics and (ii) payment methodologies that align their financial and contractual incentives with those of the Health Plan through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

4. Cumulative Provisions. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers. Contracted Provider agrees to include the terms and conditions contained herein in its contracts with Providers. This Attachment may be updated as required by the Nebraska Contract, DHHS or other Governmental Authority.

5. Value-Based Contracts. Contracted Provider agrees that all applicable terms and conditions in the Nebraska Contract, any incorporated documents, and all applicable State and federal laws, as amended, including, without limitation 42 C.F.R. § 434.6, govern Contracted Provider's duties and responsibilities with regard to the provision of services to Members. **[NE Contract § IV.Q.6.c.]**

6. Emergency Services. Providers shall not be required to seek prior authorization for Emergency Services before the Member has been stabilized. Once a Member who receives Emergency Services is stabilized, the Provider shall seek prior authorization for Post-Stabilization Care Services for the Members specified in 42 CFR 438.114(e) and 42 CFR 422.113(c)(2). **[NE Contract § IV.E.14.b.]**

7. Covered Population. The covered population includes Health Plan's Members covered under the Nebraska Contract.

8. Unique Identifier. Providers who are physicians shall have a unique identifier in compliance with 42 USC § 1396u-2(d)(4).

9. NPI. All Providers that submit claims to Health Plan shall have a national provider identifier (NPI) number; this requirement shall be consistent with 45 C.F.R. § 162.410. The NPI number(s) must be the same NPI number(s) used for enrollment in the Nebraska Medicaid program. **[NE Contract § IV.S.4.h.]**

10. Cultural Competency. Providers are required to deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR 438.206(c)(2). **[NE Contract § IV.I.1.k.]**

11. American Indian Health Protections. In compliance with Section 5006(a) of the American Recovery and Reinvestment Act (ARRA) of 2009, any American Indian who is eligible to receive, is currently receiving or has ever received an item or service furnished by an American Indian health care provider or through referral is exempt from all copayments, cost sharing or similar charges. **[NE Contract § IV.F.1.b. (iii)]**

12. Mainstreaming of Members. To ensure mainstreaming of Nebraska Medicaid members, the Provider must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The Provider must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f): (i) denying or not providing a member any covered service or access to an available facility; (ii) providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary; (iii) subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and (iv) assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served. **[NE Contract § IV.I.3.a.]**

13. Deficit Reduction Act. In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), Contracted Provider shall, and shall require the other Providers to, comply with Health Plan's Fraud and Abuse Prevention Policy, as revised from time to time by Health Plan, and as otherwise may be required under the Nebraska Contract.

14. Compliance with Laws. The parties must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. **[NE Contract § IV.C.2.a.]**

15. Physician Incentive Plan Programs. The Parties shall comply with the requirements of the Physician Incentive Plan (PIP) regulations contained in 42 C.F.R. § 438.6(h), 42 C.F.R. §§ 422.208 and 422.210. No specific payment will be made directly or indirectly as an inducement to reduce or limit Medically Necessary services furnished to a Member. Contracted Provider shall provide any physician incentive plan information in an accurate and timely manner to Health Plan in the format requested by Health Plan. As applicable, Contracted Provider agrees to incorporate the requirements of the PIP regulations and this provision into its agreements with any persons/entities for the provision of services under this Agreement. **[42 C.F.R. 417.479, 422.208, 210] [NE Contract § IV.Q.7.]**

16. Maintenance of Records. Contracted Provider shall maintain an adequate medical record system which includes a complete medical record for each Member in accordance with State laws and regulations. In addition, Contracted Provider will maintain a medical records system which maintains inactive medical records. Contracted Provider must document all medical services that the Member receives in accordance with all applicable laws and consistent with utilization control requirements in 42 C.F.R. § 456. Contracted Provider must maintain Members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an accurate system for follow-up treatment. Contracted Provider will maintain methods and procedures that guarantee each Member the right to request and receive a copy of his or her medical records. Medical records must be legible, signed, dated and maintained in accordance will all applicable Laws. The Provider must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The Provider must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed. **[NE Contract § IV.R.13.]**

17. Response to Record Requests. Contracted Provider shall furnish duly authorized and identified agents or representatives of the State and federal governments, including but not limited to, the MLTC, the Secretary of the Department of Health and Human Services ("DHHS"), the DHHS Office of the Inspector General ("OIG"), or the Nebraska Medicaid Program Integrity Unit ("NMPI"), Medicaid Fraud and Patient Abuse Unit ("MFPAU")and Health Plan with such information as they may request regarding payments claimed for Medicaid services. The Contracted Provider must timely provide copies of the requested records within ten (10) business to the agency, the agency's designee (including Health Plan) or MFCU from the date of the request, unless the agency or MFCU sets, at its sole discretion, a period greater than 10 days. If such original documentation is not made available as requested, Contracted Provider, must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal office of Contracted Provider (or Contracted Provider's other locations, as applicable). Additionally, Contracted Provider agrees to grant the MLTC, DHHS, OIC, MFCU and/or Health Plan access during regular business hours to examine health service and financial records related to a health service

billed to the program. The MLTC will notify Health Plan no less than twenty-four (24) hours before obtaining access to a health service or financial record. **[42 C.F.R. 434.6, 438.6]**

18. Confidentiality of Member Records. Contracted Provider agrees in accordance with 42 C.F.R. § 438.224, that all Member medical records, as well as any other health information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in HIPAA, including confidentiality of family planning services. Contracted Provider further agrees to protect and maintain the confidentiality of mental health information and to release mental health information only as allowed and to release substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and federal law and regulations. Contracted Provider agrees to notify Health Plan within one (1) day upon discovery of a non-HIPAA –related breach.

19. Business Transaction Disclosures. Contracted Provider shall provide full disclosure of significant business transactions as set forth in 42 C.F.R. § 455.105. Contracted Provider shall submit, within thirty (30) calendar days of a request made by MLTC, federal DHHS or Health Plan, full and complete information about: (i) the ownership of any subcontractor with whom the Contracted Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (ii) any significant business transactions between the Contracted Provider and any wholly owned supplier, or between the Contracted Provider and any subcontractor, during the five (5) year period ending on the date of the request. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request within the time requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract. **[NE Contract § IV.T.3.]**

20. Ownership Disclosures. Contracted Provider shall make full disclosure of ownership, management and control information for the Contracted Provider, any subcontracting entities or Providers as required by 42 C.F.R. §§ 455.100 through 455.106. This information shall be delivered to Health Plan upon execution of this Agreement, and to Health Plan or MLTC within thirty (30) calendar days after any change in ownership. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request within the time requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract. **[NE Contract § IV.T.2.]**

21. Cost Sharing and Member Liability. Contracted Provider, and/or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the State to Health Plan or nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Contracted Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons, other than the Health Plan, acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with the terms of the agreement between Health Plan and Members. In compliance with 42 U.S.C. § 1396u-2(b)(6), Contracted Provider shall not bill Members for Covered Services any amount greater than would be owed in the entity provided the services directly (i.e., no balance billing by Providers). Contracted Provider, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf. **[NE Contract § IV.C.16.]**

22. Continuation of Benefits. Continuation of benefits shall be in accordance with Nebraska laws and the Nebraska Contract. Upon the termination of the Agreement, except if the termination is for cause by Health Plan, Contracted Provider agrees to continue to provide care for non-pregnant Members who are undergoing a course of treatment for ninety (90) days, or if sooner, upon completion of the prescribed treatment plan. Contracted Provider agrees to continue to provide care to pregnant Members in their second or third trimester of pregnancy through postpartum care related to the child birth and delivery, which shall also include the post-partum visit. **[NE Contract § IV.S.17.c.]**

23. Provider Preventable Conditions. No payment will be made for provider-preventable conditions, as identified by the Nebraska Contract, or applicable federal or State law, as any may be amended. Contracted Provider agrees to comply with the reporting requirements of 42 C.F.R. § 447.26(d) as a condition of payment. **[42 C.F.R. 434.6] [NE Contract § IV.Q.12.]**

24. Coordination of Benefits. Contracted Provider must coordinate benefits in accordance with 42 CFR 433.135, et seq., and agrees not to pursue collection from the member but to identify third party liability coverage, including without limitation, Medicare and long-term care insurance as applicable, and except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004, seek such third party liability payment before submitting claims to Health Plan. **[NE Contract § IV.S.15.a.(v. and xi.)]**

25. Claim Submission. Contracted Provider shall submit Clean Claims, which do not involve a third party payer, promptly. Upon termination or expiration of the Agreement, Contracted Providers shall supply all information necessary for reimbursement of any outstanding medical claims. **[42 C.F.R. 434.6]**

26. Nondiscrimination. Health Plan will not discriminate for the participation, reimbursement or indemnification of Providers acting within the scope their license solely on the basis of that license or certification and will not discriminate against Providers who serve high-risk populations or specialize in conditions that require costly treatment. **[42 C.F.R. 438.12, 42 C.F.R. 438.214] [NE Contract § IV.I.2.b.]**

27. FQHCs/RHCs. If Contracted Provider is an FQHC or RHC, this Agreement provides for reimbursement for the FQHC/RHC at the Prospective Payment System (PPS) rate in effect on the date of service for each encounter in accordance with 471 NAC Chapters 29 and 34. **[NE Contract § IV.Q.9.**

28. Timely Access. Contracted Provider must meet the Nebraska Contract timely access to care and services standards. Contracted Provider must meet the hours of operation and appointment time requirements set forth in the Nebraska Contract and Health Plan's Provider Manual. Contracted Provider agrees to maintain hours of operation for Members no less than hours of operation offered to commercial enrollees or comparable to other Medicaid fee-for-service enrollees. Contracted Provider shall be available to Members twenty-four (24) hours a day, seven (7) days a week as required by the Nebraska Contract and Contracted Provider acknowledges that Health Plan shall implement corrective actions for Providers identified through the audit as failing to meet this standard. **[NE Contract § IV.I.1.g.]**

29. Newborn Enrollment Notification. If Contracted Provider is a hospital, Contracted Provider agrees to report births of Members to the Health Plan within 24 hours of the birth. **[NE Contract § IV.B.4.d.]**

30. Provider-Patient Relationship. Subject to the limitations described in 42 CFR 438.102(a)(2), Health Plan agrees that it will not prohibit or otherwise restrict Contracted Provider from advising or

advocating on behalf of a Member who isa patient of the Provider, regardless of whether benefits for such care or treatment are provided under the contracts, regarding: (i) the Member's health status; (ii) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (iii) any information the Member needs in order to decide among all relevant treatment options; (iv) the risks, benefits and consequences of treatment or non-treatment; or (v) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. **[NE Contract § IV.J.7.]**

31. Patient-Centered Medical Homes. Health Plan agrees to promote and facilitate the capacity of its provider to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Patients must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute and chronic needs of members, using best available evidence and appropriate technology. **[NE Contract § IV.I.7.]**

32. Excluded Persons. Contracted Provider agrees that it will not execute any agreement with an individual or entity that has been excluded from participation in the Medicare, Medicaid, and/or CHIP Programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with a State's Medicaid program or the Medicare program. Contracted Provider agrees to disclose the identity of any person excluded or who may be excluded to Health Plan immediately upon Contracted Provider's knowledge. Contracted Provider shall disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1). Health Plan must abide by any direction provided by the DHHS regarding whether or not to permit a Provider for participation in Health Plan's network. If any person who has ownership or control interest in Contracted Provider, or who is an agent or managing employee of Contracted Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XXI Services program, or if DHHS or Health Plan determines that Provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Health Plan shall not permit the Provider into the provider network.

33. Laboratory Services. If Contracted Provider is an entity that provides laboratory services, it agrees to comply with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 C.F.R. Part 493, Subpart A, as amended. Verification of CLIA licensure (including the CLIA Identification number) or Certificate of Waiver during the provider registration process is required. Payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings. **[NE Contract § IV.I.9.]**

34. Obligation to Suspend Payment to Providers. Health Plan, in compliance with 42 C.F.R. § 455.23 and the Nebraska Contract, shall suspend payments to a provider when there is credible allegation of fraud. NMPI will determine whether to suspend payments or if an exception is appropriate. Health Plan will comply with the applicable provisions of 42 C.F.R. § 455.23 and the Nebraska Contract when implementing this provision. **[NE Contract § IV.8.b.xvi]**

35. Termination of Providers. Health Plan shall comply with all requirements for provider disenrollment and termination as required by 42 C.F.R. § 455.416.

36. Enroll In State Medicaid Program. All Providers participating under this Agreement must first enroll with State Medicaid. **[NE Contract § IV.I.13.a.]**

37. Certification Regarding Lobbying. Contracted Provider certifies that no federal appropriated funds have been paid or will be paid on behalf of the Contracted Provider or any subcontractor or Provider to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the Nebraska Contract, grant loan, or cooperative agreement, Contracted Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. **[45 CFR § 3]**

38. Additional Requirements for Home and Community-Based Service (HCBS) Providers. If Contracted Provider and/or any Providers participate in Health Plan's HCBS Program ("HCBS Provider"), they shall ensure non-institutional Long Term Services and Support are provided in settings that comport with the CMS home and community-based setting requirements as defined in regulations at 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a). In accordance with 42 C.F.R. § 441.301(b)(1), Contracted Provider shall ensure that waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or IDF/ID.

ATTACHMENT C
COMPENSATION

(See following attachments)

DRAFT

ATTACHMENT C-[#]
NEBRASKA MEDICAID AND CHP COMPENSATION
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Nebraska Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses, if any:

[TO BE NEGOTIATED WITH PROVIDER]

3. Health Plan shall process claims and pay or deny a Clean Claim within the time period required by applicable Laws or the Nebraska Contract. The date of receipt is the date the Health Plan receives the Clean Claim as indicated by its data stamp on the claim. The date of payment is the date of the electronic funds transfer, check or other form of payment.

4. Health Plan may adjust claim payments due to coordination of benefits or subrogation.

5. Health Plan implements and prospectively applies Department's changes to its Nebraska Medicaid fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date the Department publishes the change on its website. Health Plan will not retrospectively apply rate changes to claims that have already been paid.

6. Health Plan may update code numbers or delete retired codes without notice or amendment to this Agreement as such are revised or implemented by the Department from time to time. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for items and services that are not included in the Department's payment system or fee schedule published on the its website.

7. The amount of compensation paid is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials. For example, a Provider who is a licensed clinical social worker (LCSW) will be paid at the rate for LCSWs, regardless of whether the LCSW has an advanced degree.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

39. Describe the MCO's required PCP responsibilities and how the MCO will verify PCPs are performing them. *(Page limit 2 pages)*

PRIMARY CARE PROVIDER RESPONSIBILITIES AND VERIFICATION PROCESS

Our primary care network will include a broad range of qualified primary care provider types including specialists who have agreed to assume the roles and responsibilities of a PCP for members with special health care needs. Any American Indian member may choose a participating Indian Health Service/Tribal Health (638 Clinic) /Urban Indian Health (I/T/U) provider as their PCP as long as the provider participates as a PCP and has capacity to provide the service.

Our provider contract and handbook document the PCP responsibilities that providers must agree to in order to be available as a PCP choice to members. WellCare proactively engages with our PCPs to support them in the delivery of their responsibilities and verifies their performance through multiple avenues including:

- Field-based provider services representatives who have up to 18 office visits or telephonic meetings per year with PCPs
- Field-based clinical HEDIS practice advisors (CHPAs) who meet with PCPs in their office up to four times a year. CHPAs partner with providers on the importance of quality care and use health outcomes data at the provider level to monitor care gaps for members
- Nebraska medical director who oversees care delivery, designs interventions, and meets with PCPs for coaching and education
- Nebraska pharmacy director who meets monthly with up to 25 providers on prescribing patterns
- Provider data analytics and profiling allowing us to profile providers, evaluate clinical treatment and protocols provided to our members, and identify gaps in care
- Member complaints and grievances which are investigated promptly with quality of care findings included in the provider's credentialing file along with information on corrective actions ordered and verification of implementation
- Emergency department monitoring reports delivered to high-volume PCPs so they may redirect their members to the primary care setting
- Quarterly Member Advisory Committee meetings providing feedback on PCP performance
- Quarterly provider office surveys validating appointment availability and wait time standards
- Member satisfaction surveys
- Credentialing and re-credentialing

See **Figure 3** for a sampling of PCP responsibilities and the verification process for each.

Figure 3

PCP Responsibility	Verification Process
• Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under the age of 21	• Provider services representatives, CHPAs, medical director, pharmacy director, data analytics and profiling, member complaints and grievances, emergency department monitoring, medical record review
• Routine office visits for new and established members, including hearing services, counseling and risk intervention, family planning, immunizations, x-	• Data analytics and profiling, medical record review, member advisory committee, program integrity

PCP Responsibility	Verification Process
ray and medically necessary laboratory services, in-office tests and procedures	
See members for an initial office visit and assessment within the first 90 days of enrollment	CHPAs, data analytics and profiling, complaints and grievances, emergency department monitoring, member advisory committee, satisfaction surveys
Initiating and/or authorizing referrals for specialty care	Data analytics and profiling, complaints and grievances, medical record review, member advisory committee, satisfaction surveys
Provide appropriate referrals of potentially eligible women, infants, and children to the Women, Infant and Children (WIC) program for nutritional assistance	Provider services representatives, complaints and grievances, member advisory committee
Provide or arrange for coverage of services, consultation or approval for referrals 24 /7. Maintain 24-hour on-call coverage in accordance with WellCare standards	Provider services representative, complaints and grievances, member advisory committee, provider office survey, satisfaction surveys , credentialing
Adhere to the standards of timeliness for appointments and in-office wait times for various types of services that take into consideration the immediacy of the member's needs	Provider services representative, member advisory committee, quarterly provider office survey, satisfaction surveys
Assure members are aware of the availability of public transportation where available	Provider services representative, member advisory committee, satisfaction surveys
Submit an encounter for each visit where the provider sees the member or the member receives a service	Provider services representative, CHPAs, provider data analytics and profiling
Ensure members use network providers (with the exception of family planning services and I/T/U providers); contact WellCare for help locating a participating provider	Data analytics and profiling, complaints and grievances, medical record review, member advisory committee, satisfaction surveys
Comply with and participate in corrective action and performance improvement plans	Provider services representative, medical director, pharmacy director, CHPAs, program integrity
Deliver services in a culturally competent manner	Provider services representative, complaints and grievances, member advisory committee, satisfaction surveys
Maintain continuity of care and participate in an inter-disciplinary care team	Medical director, pharmacy director, CHPAs, medical record review
Maintain the member's medical record in accordance with state and WellCare requirements	CHPAs, medical record review
Maintain admitting and treatment privileges at one or more network general acute care hospitals or, subject to WellCare approval, have written arrangements with at least one other network provider with admitting and treatment privileges at a network hospital	Provider services representative, credentialing
Fulfill all contractual responsibilities defined in the quality improvement program description	Medical director, pharmacy director, provider services representative, CHPAs, data analytics and profiling

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

40. Describe innovative strategies the MCO's intends to use to identify specialty types for which member access is limited. Describe the MCO's intended initiatives for increasing the number of specialists within those specialty types that participate in the MCO's network.

Identify potential challenges the MCO anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the MCO will mitigate those challenges. *(Page limit 3 pages)*

INNOVATIVE STRATEGIES TO IDENTIFY WHERE ACCESS IS LIMITED

WellCare has actively researched the unique network development challenges in Nebraska and met with hundreds of stakeholders in the state. In our discussions with Nebraska providers, professional organizations and advocacy organizations, access to care in rural and frontier communities, particularly specialty care, was one of the most commonly identified issues related to closing health disparities between frontier, rural, and urban counties.

Key facts we have learned about the challenges associated with serving the rural, frontier, and underserved areas in Nebraska include:

- 48 of Nebraska's 93 counties did not have a mental health provider in 2014 (source June 2015 Nebraska Behavioral Health Workforce report)
- 83 of Nebraska's counties were designated mental health shortage areas, eight were partially designated
- More than half of the licensed mental health workforce is over the age of 50
- Significant workforce shortages exist for Nebraska, especially in rural and frontier counties, in primary care, mental health, dentistry, family medicine, general internal medicine, general pediatrics, general surgery and pharmacy [Final Report Legislative Solutions 22 (2013) and 42(2014)]

Our meetings with professional associations such as the Nebraska Hospital Association, Nebraska Medical Association, Leading Age Nebraska, Nebraska Health Care Association, Health Center Association of Nebraska, Nebraska Association of Behavioral Health Organizations, Children and Family Coalition of Nebraska and tribal clinic representatives, as well as individual providers and community advocacy organizations have helped us understand how these issues are playing out and informed our strategies for addressing them.

Initiatives to Increase the Number of Specialists

WellCare constantly analyzes access data and aligns incentives and rates to support underserved areas and the closure of network gaps. We will address the challenges associated with specialist services, particularly around behavioral health, in rural, frontier, and underserved areas using some of the tools we have developed in other states, customizing them for Nebraska. These include:

Partnerships with Major Health Systems

WellCare will leverage partnerships with major Nebraska-based health systems such as the University of Nebraska to leverage existing satellite programs for primary and subspecialty care and look for opportunities to help expand those opportunities where appropriate. We will also use telehealth as a tool to connect rural and frontier PCPs to urban health care systems and to link rural and frontier providers with other providers for peer support and counseling. In our meetings with Boys Town, for example, we discussed how we might support their efforts to expand telehealth capabilities in each of its clinics to provide access back to specialty providers, particularly for children's psychiatry services.

Supporting PCPs in the Delivery of Behavioral Health Services

The shortage of psychiatrists being experienced nationwide requires an array of unique strategies that include supporting and enhancing the PCP's role. Our strategies include training PCPs to bolster their role in prescribing and medical management, supporting prescribing PCPs with counseling for members, and enhancing telehealth opportunities to provide consultation to PCPs.

Mid-Level Provider Types

Advanced practice nurses (APNs) and physician assistants can be critical to increasing access to health care, often offering services in remote locations where physicians may not be available. Legislative Bill 107 reduced barriers to full practice for APNs. WellCare will include access to APNs and physician assistants to the full extent allowed under Nebraska law. We will also rely on the availability of certified nurse midwives.

Mobile Health

We will recruit providers who are able to provide mobile health care services in locations convenient to our members. We have employed this mobile strategy in other states to increase capacity to provide services and fill care gaps in remote locations or in states with provider shortages.

Behavioral Health

We will use specific strategies to increase access to behavioral health services in underserved areas. These strategies are based on our understanding of the shortage of behavioral health professionals in Nebraska and the long preparation time for licensure. These include:

- **Behavioral Health Toolkit**: Our behavioral health toolkit supports the integration of behavioral health and primary care. The toolkit, which is posted on our website and featured in provider newsletters, helps PCPs manage their members with co-occurring behavioral health conditions. Plans are underway to develop PCP training modules on recovery and resiliency programs.
- **Peer Support Resources**: Peer supports have become an effective tool in health care delivery. WellCare will support and collaborate with providers who have established innovative peer supports program such as ED Connections in Lincoln using peer supports in the emergency department and the REAL Program collaboration between the Lincoln Police Department and the Mental Health Association.
- **Behavioral Health Telehealth**: Partnerships in the delivery of behavioral telehealth services. For example, in Georgia we partnered with Hope House to sponsor a behavioral health telehealth service expansion for a residential substance abuse treatment facility. A process is now established for Hope House to refer members in the program to WellCare for physical and behavioral health care management services.
- **Integrated Health Homes**: As we continue to identify providers who could potentially pilot our Integrated Health Home model, we will develop our contracting and incentives around common interests such as improving access to services and the co-location of physical and behavioral health.
- **Provisional Licensing:** Provisionally licensed mental health practitioners can be an important option for expanding access to mental health services. It is our understanding that provisional licensure is helping in the rural and frontier areas of the state and there is a discussion underway lead in part by Legislative Resolution 185 to address the need to extend provisional licensure to urban areas in the state as well. WellCare will continue to monitor this issue and look for opportunities to expand access to mental health services.

POTENTIAL CHALLENGES AND MITIGATION STRATEGIES

Based on our time in Nebraska and our national experience, we know there are potential challenges in behavioral health services of all types especially psychiatry. In addition we anticipate challenges in

primary care and specialist services in rural and frontier counties. We will use the following strategies to mitigate these challenges.

Telehealth

WellCare will partner with providers, groups of providers, and the Nebraska Statewide Telehealth Network (NSTN) to extend health care resources to those in need using video technology. We are also working with a telehealth vendor, American Well, who provides members access to live video visits with licensed physicians and behavioral health providers 24/7 by computer or a mobile application for smart phones and tablets and established telehealth kiosks at strategic locations. Below is a member story from our Georgia affiliate where tailored telehealth solutions were deployed to meet unique needs of a member.

MEMBER STORY

Telehealth: Increasing Access to Behavioral Health Care

- An adolescent member living in a rural county experienced frequent inpatient behavioral health admissions. The family did not have the resources for transportation and did not want to utilize Medicaid transportation, and his behavioral health condition went largely untreated. In addition, the family experienced multiple socioeconomic stressors that greatly exacerbated the member's condition.
- The member was enrolled in special education services. The care manager leveraged the existing services and relationship with the school to arrange for Care Partners of Georgia to provide tele-psychiatry in the school for a weekly evaluation, assessment and medication management.
- As a result of the coordination between WellCare, the school and the provider, telehealth services were provided to create access to needed behavioral health services. The member's condition stabilized and he continues to attend school.

Contiguous States

Recognizing the patterns of care and importance of cross-border providers in the Nebraska delivery system, we will reach out to providers in contiguous states to initiate contracting. We will adhere to the payment rules and guidelines for providers in those states.

Transportation

Recognizing transportation as one of the biggest barriers to health care in Nebraska, we will facilitate coordination of transportation for members to improve access to care. We will use warm transfers and assist members in making appointments with the transportation vendor. In addition, we track all referrals to non-benefited services including transportation. In Georgia, we are piloting innovative programs with local universities to restructure bus schedules to facilitate easier access to health care within the community, benefiting our members and the communities at large.

Our Homeless Members

Understanding the issue of homelessness in Nebraska, we will build on our strategies in other states to deliver care to the homeless population through community partners. Homeless or housing challenged members represent one population who rely heavily on the emergency department for care. In Kentucky, for example, we partnered with HOTEL INC. on a street medicine program to identify homeless residents and link them with health services including preventive care outside of the emergency department.

Out-of-Network Utilization

As needed, we will develop relationships with non-participating providers to allow us to work with them on a case-by-case basis to secure member access to the appropriate level of medically necessary care. Typically, we arrange care with out-of-network providers by executing single case agreements that authorize care for a specific member.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

41. Describe the MCO's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times. *(Page limit 2 pages)*

MONITORING AVAILABILITY AND ENSURING ADHERENCE

Appointment standards for members are of primary concern to us. Providers are educated on these standards as part of their initial training and through ongoing reminders. We monitor provider adherence to appointment availability and wait times through a variety of tools including our Member Advisory Committee, quarterly provider office surveys, member surveys, complaints and grievances, member outcome data and care gaps, and feedback from member services associates, care managers, state partners, advocates, and legislators. We require that all providers offer hours of operation that are no less than the hours of operation offered to commercial or fee-for-service patients. We also require PCP providers to arrange for coverage of services after-hours. WellCare will establish and implement a Nebraska-specific policy, subject to MLTC review and approval, to ensure our network providers comply with all appointment availability access standards and wait times. We recognize that our members have the freedom to access family planning services from any appropriate Medicaid provider regardless of network participation and educate both our members and our providers on this freedom of choice. To streamline access to family planning there are no authorization or referral requirements. We also recognize that our American Indian members have the freedom to see I/T/U providers whether participating in the network or not and will work closely with tribal entities to ensure timely access to services.

Member Advisory Committee

Our Member Advisory Committee will provide valuable feedback on appointment availability and wait times. This committee meets quarterly and provides input on the quality of their customer experiences with health care providers and helps us identify root causes of barriers to receiving care as well as potential strategies for overcoming barriers.

Quarterly Provider Office Surveys

We conduct a quarterly phone audit using a sampling methodology to survey network providers for appointment timeliness, wait time, and after-hours availability. A phone survey script for each metric will be used to complete the audit for various provider types based upon the MLTC access standards found in Attachment 2.

Typically, we perform an initial audit on a statistically valid sampling of our providers for all wait time and appointment requirements. If a provider fails the initial audit, a representative from our provider services team contacts the provider by letter and recommends remediation strategies. In the following quarter, the failing provider is contacted for a second round audit to determine if the original failure has been corrected.

Kentucky Member Satisfaction

Our 2014 Kentucky Medicaid member satisfaction survey reported an adult satisfaction rate of 86.7% and a child satisfaction rate of 93% with Getting Appointments and Care Quickly.

Surveyors make three attempts to reach all providers in the sample. If a call attempt for the first provider in the sample is unsuccessful, the surveyor asks for the next provider listed at the same phone number to try to complete as many surveys for the same office as possible to minimize repeat calls to the same office for the same survey period.

Member Surveys

Member feedback is among our most valuable resources in monitoring appointment availability. Members are surveyed annually to assess their experiences with appointment availability. Selection for the survey is based on member claims data received from providers so we are specifically soliciting feedback from members who have received care. The claims are sorted by the type of service, such as: urgent care (adult and pediatric), PCP (adult and pediatric) and specialists. The member survey is based on services that have occurred in the past six months, and the results are based on a member's perception of the visit.

Member Complaints and Grievances

Complaints and grievances are closely monitored with regard to access and availability of care. When issues are identified, provider services staff members intervene to re-educate the provider on their contractual obligation to adhere to standards and corrective action plans are developed, if needed.

Local Input

Our member services associates, care managers, medical director, practice advisors, and other field-based associates offer valuable input as to access and availability of care as do our state partners, other agencies, advocates and legislators. Reports regarding lack of appointment availability and wait times are carefully investigated by our provider services team with the appropriate corrective action. Our practice advisors use health outcomes data at the provider level to monitor care gaps for members which may be an indication of an appointment availability issue.

ADDRESSING DEFICIENCIES

We take corrective action to remediate providers not adhering to appointment availability, wait time or after-hours call return time standards. By letter, we notify providers who fail compliance testing, include information about the standards, and include suggested remediation strategies. We work with network providers to amend their procedures to adhere to the standards. When appropriate the provider is contacted by a provider services representative.

We re-audit all failed providers the following quarter to determine if the education efforts are successful in changing the behavior of the providers and are successful in influencing them to meet the performance standards. Any provider that fails the re-audit is notified by letter, and our medical director makes a recommendation for peer-review and sanctions to our Credentialing Committee. Provider sanctions may include the revocation of credentials and contract termination.

PATIENT-CENTERED MEDICAL HOME

Our patient-centered medical home (PCMH) standards include requirements for patient accessibility to services such as on-call access 24/7, appointments outside traditional business hours and day-of-call appointments. As providers move to PCMH and integrated health home models we anticipate further improvements in both the ease and speed of getting appointments.

Compliance with PCMH standards is monitored routinely by WellCare and corrective action is taken through education and appropriate remediation. We also share with our PCMHs information regarding members who present to the emergency department for non-emergent care. This helps the PCMH evaluate the success of their after-hours program.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

42. Describe the MCO's approach to promoting and facilitating the capacity of its providers to provide:

- Patient-centered care.
- Improved health outcomes.
- Member compliance.
- Member satisfaction.

Discuss the MCO's successes with patient-centeredness in other Medicaid programs, what lessons have been learned, and the MCO's planned approach in Nebraska *(Page limit 3 pages)*

PROMOTING AND FACILITATING CAPACITY FOR PROVIDERS TO DELIVER PATIENT-CENTERED CARE

Provider partners are the most critical element in WellCare's approach to helping members receive the kind of patient-centered care that ultimately improves compliance and satisfaction while enhancing health outcomes and member quality of life. Having exclusively served members in government-sponsored health care programs for more than 20 years, we recognize that our members face unique challenges. Whether it's a mom in Kearney living in a homeless shelter trying to care for three children or an elderly woman in Norfolk living on SSI/Disability with barely enough money for a month's worth of food, our members enter their doctors' offices with an entirely different set of needs that require an entirely different set of strategies if we're going to be successful in improving health outcomes.

To meet these challenges, WellCare uses a multi-faceted approach to promote and facilitate patient-centered care. Our approaches are tailored based on where providers are starting from in terms of their capacity for patient-centeredness. Generally, the layers of support we offer, based on provider need, include:

- Clinical practice support and training through our clinical HEDIS practice advisers (CHPAs), medical director, pharmacy director, behavioral health manager, quality management coordinator, medical management coordinator, care managers, disease mangers, and utilization managers as well as the ongoing support of our provider services representatives, operations account representatives, and CommUnity advocates
- Sharing of data and analytics including
  - Quality dashboard with HEDIS scores, care gap reports, and quality trends
  - Measures of provider efficiency such as use of electronic funds and electronic data interchange
- Information technology (IT) infrastructure such as assistance with health information exchange (HIE) connectivity and electronic health record (EHR) support
- Care managers who educate members and partner with providers to ensure appropriate medically-necessary services are delivered to the member
- Disease managers who provide health education and chronic disease health coaching to members
- CommUnity Assistance Line offering connections to community resources to help address social barriers and needs through our award-winning proprietary Health*Connections* model
- Member incentives and education programs to support healthy behaviors, member empowerment and member engagement in their own health care
- Centralized telephonic outreach program with outreach specialists who contact members with identified care gaps and initiate a three-way call with the member's provider to help set-up an appointment to close the care gap
- Member engagement unit that outreaches to members about recent emergency department visits to reconnect them to their PCP and conducts discharge follow-up

- Integrated system of care focused on the collaboration of behavioral health providers with PCPs, service providers, hospitals and consumer/peer providers

While patient-centeredness can have many definitions, patient centered medical home (PCMH) standards established by the state of Nebraska as well as the National Committee of Quality Assurance (NCQA) PCMH standards provide a solid starting point for defining how providers practice patient-centered care. We believe the PCMH model is an important tool to promote and facilitate the capacity of providers to deliver care in a manner that supports the member's overall health and well-being and addresses the full spectrum of services, whether physical, behavioral, pharmacy or social.

We know that Nebraska has been a leader on this initiative, beginning with the legislatively created medical home pilot in Medicaid that began in 2010. The ground-breaking PCMH Participation Agreement with multiple insurers implemented last year means that 83.1 percent of Nebraskans live in counties with a PCMH. Leveraging the PCMH model to promote and facilitate patient-centered care is a natural fit in Nebraska.

However, we believe it is critical to recognize that providers are at different stages in terms of their capacity to be patient-centered. To ensure they are appropriately supported, we tailor our multiple layers of support to facilitate patient-centered care, improved health outcomes, member compliance and member satisfaction. So, for instance, a provider operating as a mature integrated PCMH or Integrated Health Home with embedded care management may benefit more from our support in the form of data analytics and care gap reporting than a provider without care coordination who may benefit from a more hands-on care management approach.

It's important to note that regardless of where providers are on this spectrum, our primary focus is on quality, and our incentive programs and investments in providers are predicated on improving health outcomes.

Successes in Other States with Promoting Patient-Centeredness

Since the health home model is one of the most direct links to identifying providers as being patient-centered, several of our affiliates have placed an emphasis on promoting PCMH standards to help providers achieve patient-centeredness goals and improved health outcomes. For example, our Georgia affiliate has aligned itself as a formal NCQA PCMH recognition program partner in quality, which means they provide an array of incentives and supports to promote and facilitate the PCMH model. For example, PCMH standards require providers to offer after-hours appointment – a general best practice for patient-centered care. To support this particular part of the PCMH effort, WellCare of Georgia introduced an enhanced reimbursement to incent PCPs who increase access to primary care services through after-hours appointments. They monitor after-hours codes to track utilization of these services to determine if other initiatives are warranted. ***This incentive, coupled with their Emergency Department (ED) Diversion program, has contributed to a 7 percent decrease in ED utilization in the Medicaid population since 2012, and in a 10 percent decrease in ED utilization in the SCHIP population.*** WellCare of Georgia's data overall provide empirical evidence that investments in redesigning the delivery of care around a PCMH model result in reductions in emergency department visits and inpatient hospitalizations, as shown in **Figure 4**.

Figure 4

WellCare of Georgia PCMH Versus Non-PCMH Utilization 2013			
Measure	**Non-PCMH Practices**	**PCMH-Recognized Practices**	**Percent Reduction for PCMH Practices**
Emergency Department Visits per 1,000	647	579	10.5%
Inpatient Admits per 1,000	39	24	38.2%

WellCare of Georgia PCMH Versus Non-PCMH Utilization 2013			
Measure	Non-PCMH Practices	PCMH-Recognized Practices	Percent Reduction for PCMH Practices
Inpatient Days per 1,000	141	91	35.5%

Lessons Learned

Our patient-centered care program represents an evolution of both successes and lessons learned. Some of those are summarized below:

- The PCMH model should support the provider where the member is receiving the majority of his or her health care whether it is in a primary care, behavioral, specialist, or long term care setting.
- Integration of physical and behavioral health services is a critical component of patient-centeredness. The rate of co-morbidity among Medicaid members requires a strong integrated approach to care. This could be accomplished through co-location, consultation or rapid referral processes.
- Practice readiness is key, and pre-assessment tools that identify resources and EHR capabilities are essential supports for provider offices.
- To support their patients, providers need assistance around solving for social determinants of health.

Planned Approach in Nebraska

As noted above, we tailor our approach to meet providers where they are, so working with a provider group like Southeast Regional Physicians Association (SERPA), the Nebraska Health Network or the clinics of Children's Hospital & Medical Center of Nebraska will look different than working with smaller practices or practices less advanced in their PCMH efforts.

One part of our approach that is standard is assistance with referral to and accessing community resources to address social determinants of health. Our CommUnity Assistance Line will be available to practices seeking help for their members for everything from access to healthy food to housing or utilities assistance. We already have more than 5,000 organizations in our CommUnity database, and our method of tracking referrals for our members ensures that we are able to tie health outcomes to the social help they are accessing.

Additionally, as noted above, we will flex our care management strategy based on certain to-be-determined criteria so if embedding a care manager in a practice makes sense, we will take that approach. If providing more of a clinical liaison roll to more advanced practices is warranted, we'll do that to support those care coordination functions. Some other tailored approaches we would deploy in Nebraska based on our experiences in states like Florida, Georgia, Hawaii and others include:

Data and Analytical Support: Even advanced providers often have gaps in their data like hospital readmissions or emergency department use. We will help providers at all levels fill those gaps by providing strong data and analytics and walking providers through their individual profiles, care gap reports and HEDIS-based outcomes metrics.

Technical Support: For providers seeking PCMH certification, integration, co-location or other practice transformation efforts that support patient-centered care, we have an array of support tools to offer, including access to our PCMH expertise for such things as writing policies and procedures or best practices for integrating behavioral and physical health care within a practice.

NeHII and EHR Support: We will support our providers in the adoption of Nebraska Health Information Initiative (NeHII) and leverage our value based purchasing program to provide incremental payment bonuses to non-PCMH practices with a minimum panel size who adopt EHRs. The payments will reward providers who adopt EHRs, even if they are not fully recognized as PCMHs.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

43. Describe how the MCO's network development plan will establish patient-centered medical homes consistent with the requirements included in Section IV.I Provider Network Requirements. The description must address requirements in the RFP including:

- Promoting and facilitating provider capacity to meet PCMH standards.
- Maintaining contact with members throughout their interactions with the health care system.
- Managing referrals.
- Illness and disease prevention.
- Encouraging active participation of the member or family/guardian/authorized representative in health care decision-making
- Encouraging the use of specialty services and supports.
- Providing access to care outside normal business hours.
- Facilitating open scheduling and same-day appointments where possible.

(Page limit 5 pages)

HELPING TO IMPROVE MEMBER OUTCOMES THROUGH PATIENT CENTERED MEDICAL HOMES

WellCare of Nebraska's Patient Centered Medical Home (PCMH) development plan focuses on increasing the number of smaller provider practices attaining PCMH recognition while supporting providers to meet PCMH requirements through facilitation and promotion of patient-centered care strategies.

We know that Nebraska has been a leader in the PCMH movement establishing state-level criteria and working at all levels – government, payer and provider – to significantly increase access of residents to PCMH-recognized practices with 83.1 percent of Nebraskans now living in counties with at least one PCMH. WellCare's goals and experience around promoting PCMHs is aligned with the state's goals of building medical and health homes to drive improved population health outcomes. We will submit a formal PCMH Implementation Plan to MLTC 90 calendar days of the date of this contract.

The goals of our PCMH Program include:

- Increase the number of providers and practice sites in our network with PCMH recognition which will help increase the number of members cared for by a PCMH recognized provider
- Improve access to our network PCPs through the extended hours, open schedules, same-day appointments, and after-hours coverage offered through the PCMH model
- Improve our member's experiences of care including social services
- Encourage members to seek routine care and care for ambulatory sensitive conditions from their PCP rather than the emergency room
- Manage chronic conditions in a proactive rather than a reactive way through the creation of care treatment plans and the use of specialty services and supports
- Encourage more members to have well-care or well-child appointments
- Encourage active participation of the member or family/guardian/authorized representative in health care decision-making
- Improve the management of referrals with the PCMH maintaining contact with members throughout their interactions with the health care system

- Improve patient safety through the use of comprehensive medical records
- Provide members with education about their health and self-management tools for chronic conditions
- Most importantly, help members establish better relationships with their PCPs

Providers are educated on the PCMH Program by our provider services representatives and our clinical HEDIS practice advisors (CHPAs) as part of their site visits. Additionally, we will provide information about PCMH standards on our provider website.

PROMOTING AND FACILITATING PROVIDER CAPACITY TO MEET PCMH STANDARDS

We deploy five primary strategies to facilitate and promote the capacity of providers to meet PCMH strategies depending on provider size, individual needs and requests:

- Provide infrastructure and start-up support and/or grant money particularly for adoption of an Electronic Health Record and to connect to Nebraska Health Information Initiative (NeHII)
- Provide technical assistance to get started through education, support and assistance with such items as necessary Policies and Procedures and sharing of best practices
- Develop reimbursement mechanisms that reward improved quality health outcomes and recognize the role achieving PCMH standards plays in achieving improved performance
- Provide ongoing data, assistance and support to their care coordination efforts for our members
- Share information about our CommUnity resources program to help them better connect their patients to community agencies that help address social determinants of health such as homelessness or food insecurity

Payment methodology to support transformation

WellCare recognizes the considerable effort and investment that practices make to achieve PCMH recognition. We also believe strongly in structuring value-based reimbursement strategies around quality health outcomes. To make sure we support providers in their efforts to transform and meet the patient-centered standards of the PCMH model, ***we will offer in Nebraska financial incentives based on panel size and other criteria that will encompass such standards as adoption of an electronic health record, HIE connectivity and after-hours access.***

PCMHs will also be eligible for our value-based reimbursement options that meet them where they are in their own development. From basic fee-for-service (FFS) or capitation with quality bonuses, to shared savings, to full risk models, to global capitation, we are prepared to work with our PCMH providers and others to match the right model of reimbursement with their practice.

While we offer many different value-based purchasing programs across our Medicaid markets, most can be categorized into two core frameworks:

- **Pay for Quality (P4Q):** Offers PCPs a per member per month (PMPM) bonus for achieving specified quality of care targets which are usually based on HEDIS measures.
- **Gain / Risk Sharing with Quality Standards:** Larger provider organizations, including PCP groups and health systems, who meet the criteria and display a willingness to participant in shared savings, are offered the opportunity to earn a portion of the savings achieved when they meet specified quality and cost efficiency performance targets.

We will work with existing PCMH's in Nebraska and emerging PCMH's to design the right payment methodologies for them and that stay focused on improved member health outcomes and enhanced quality of life.

Facilitating Integrated Behavioral Health Care

With Nebraska offering an integrated platform of care for the Heritage Health program, we also believe it's critical to build on our current PCMH Program to increase the availability of Integrated Health Homes

(also known as Behavioral Health Homes). In the IHH model, the behavioral health specialist takes on the role of serving as the member's home for care, and they are responsible for coordinating physical and behavioral health care, as well as other specialty, rehabilitative and recovery services.

We have developed a detailed program description, clinical and payment models for IHH programs and have already had early conversations with providers in Nebraska interested in pursuing integration. The IHH program encourages whole person orientation, enhances access to care, coordination and integration of care, quality and safety and evaluation through quality metrics. ***This model promotes the integration of behavioral health providers with other programs and services members receive to promote their recovery, empowerment, and use of their family's strengths to achieve members' clinical goals and health outcomes.*** In addition, we will also work with all of our PCMHs to coordinate rehabilitation programs that promote and provide skill building, community support, supported employment and full competitive employment by members. This includes recovery support services, natural community supports and anonymous recovery programs for members and their families. **Figure 5** provides an example of successful PCMH partnerships.

Figure 5

BEST-IN-CLASS: WELLCARE OF GEORGIA LEADS PCMH EFFORTS

WellCare of Georgia is recognized as a formal Partner in Quality with the NCQA's PCMH Recognition Program because of its longstanding and ongoing support of PCMH practices. As an NCQA Partner in Quality, WellCare of Georgia is able to offer a 20 percent discount per clinician on the NCQA's submission fee for PCMH recognition.

"We are thrilled to have WellCare as an NCQA Partner in Quality to help promote coordinated, quality care to their members," said Margaret E. O'Kane, NCQA president. "WellCare knows that the NCQA PCMH program raises the bar in defining high-quality care and we are happy to support their strategy to expand coordinated care."

MAINTAINING CONTACT WITH MEMBERS THROUGHOUT THEIR INTERACTIONS WITH THE HEALTH CARE SYSTEM

WellCare's Care Model is grounded in the concept of member-centricity and assisting members to navigate the health care and social services systems. We provide in-person care management services for members with the most complex co-morbid conditions and chronic needs and have multiple levels of telephonic care management support including disease management and wellness. When working with members already engaged in a PCMH, we are able to flex our care management structure depending on how much care coordination is already being provided to avoid duplication. One key role for us is to help providers maintain contact with their patients throughout their engagement in the health care system.

We have several strategies to do this including:

- Engaging providers in Interdisciplinary Care Teams (ICT), which are established for members in care management programs to help drive care planning and monitoring the care plan
- Sharing Care Gap reports with providers so they can monitor the needs of their members and close gaps in care such as preventive and wellness visits
- Sending providers lists of new members who select them or are auto-assigned so they can make contact and get them in for an initial visit
- Sharing contact information and reaching out to providers as part of our Unable to Contact (UTC) protocols so providers can partner with us to reach hard-to-reach members
- Sharing data on Emergency Room visits and other member experiences to drive interventions

Managing Referrals

The use of EHRs can assure that information from multiple, diverse sources can be pulled together into a single system to support the comprehensive information needs of the PCMH. It is also an important referral management tool. To support providers in moving toward a PCMH recognition program, we leverage our flexible reimbursement strategies to provide incremental payment bonuses to practices with a minimum panel size and who meet other criteria who adopt EHRs. The payments will reward providers who adopt EHRs, even if they are not fully recognized as PCMHs. We will also be supporting providers who can engage in NeHII, which is a great way to help track member care as it relates to referrals.

WellCare will also monitor PCMH compliance with this core competency standard as part of our ongoing oversight of the PCMH program. Additionally, we can help providers manage referrals for their patients through many of the same strategies noted above such as the ICT, defined care plan, data sharing and care gap reporting.

Social Service Referrals

Understanding that disadvantaged populations often face barriers to good health and recovery that go beyond traditional covered services, WellCare has developed tools to help the PCMH find needed social services for their patient. Our Health*Connections* Model identifies the available social safety net providers within the WellCare footprint, assesses the critical service gaps (existing and potential) and identifies ways to sustain the network of the social safety net. Our PCMH partners are encouraged to call our CommUnity Assistance Line when they identify patients in need of social services. Once referred, our CommUnity Assistance Line arranges for needed social services and tracks them through to delivery.

Illness and Disease Prevention

WellCare makes disease management material available to our providers based on the needs of the individual member and offers case manager support in the development of embedded on-site care management services. We have a library of wellness and prevention materials available to providers to help them meet this ongoing requirement. Additionally, our CommUnity Advocacy staff offers wellness programs that can be accessed by providers seeking additional resources for their members.

The WellCare Disease Management Program is designed to be complimentary and supportive to our members. A member may be referred directly to the Disease Management Program or referred upon completion of the Short term or Complex Case Management Programs. The Disease Management Program staff has full view of the member's assessments, case notes and health care claims to deliver education, guidance and support for the primary chronic condition for which a member may need additional support, and this information can be shared with the PCMH or PCP as part of our ongoing coordination on member care.

Disease Management Program members are offered supportive disease specific educational materials from our Vendor Partner, Krames written in easy to understand language for better management of their condition. Upon completion of the Disease Management Program, the member is offered supplemental condition specific mailings twice a year via mail as long as desired. Additionally, a Health Coaching Program is available to support members who desire to address weight management (Obesity) or smoking cessation. These programs are designed to be offered as a unique program or in collaboration with Case or Disease Management Program.

We also provide our network practices access to secure, on-demand data, analytics and actionable reports from anywhere using an internet browser and a secure login. The reports include data and information that is key to managing a panel of members and critical to a provider's advancement in achieving and succeeding under a PCMH model of care. Resources include:

- Population management reporting from our predictive modeling tools

- Provider profiling to assess under- and over-utilization
- Efficiency and quality metrics such as HEDIS
- Rates of readmissions, emergency room visits, and high-cost outpatient radiology

These tools give PCMHs access to a variety of dashboards and reports so that they can easily identify opportunities to improve member outcomes and reduce costs.

Encouraging Active Participation of the Member In Health Care Decision-Making

WellCare will educate, support and monitor providers moving towards PCMH designation on the importance of the participation of the member or family/guardian/authorized representative in health care decision-making. We will offer our patient education and self-management tools to the PCMH, as appropriate, to facilitate this activity. Additionally, our care planning process which includes PCP participation is member-centered, so members and their caregivers are actively involved.

Encouraging the use of Specialty Services and Supports

Our integrated care model supports the coordination of all services including behavioral health and specialist care. The PCMH is responsible for developing a care plan that includes coordination with all specialists. As part of our oversight process, WellCare will review management reports to confirm evidence of coordination of care with all specialists. When issues arise, we will educate the PCMH and provide tools, as needed, to support coordination activities.

WellCare also supports PCMHs in the delivery of appropriate behavioral services in a PCP setting. Through our monitoring of PCMH activities we are able to identify care gaps such as antidepressant medication initiation and maintenance to increase visibility to the PCMH on their members' needs.

Our integrated model of care also supports the co-location of physical and behavioral health services. We have held preliminary discussions with Nebraska providers about the need to expand the co-location services in Nebraska.

Providing access to Care Outside Normal Business Hours

PCMH standards require the PCMH provide access to care outside normal business hours. Our data analytics package includes members who present to the emergency room for non-emergency care. This helps the PCMH identify those members in need of outreach and evaluate the success of their after-hours program. We also have the experience of providing incentive payments to certain providers for offering after-hours enhanced access to routine and urgent care.

Facilitating Open Scheduling and Same-Day Appointments

PCMH standards require the PCMH facilitate open scheduling and same-day appointments. To help the PCMH evaluate the success of their process, WellCare monitors member use of non-emergent use of the emergency department and provides this information to the PCMH. Additionally, we can provide best practices to help providers figure out how open scheduling can work for them.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

44. Describe how the MCO 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 PBM.
- 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.

(Page limit 3 pages)

A FOCUS ON CONTINUITY OF CARE --TERMINATION OR LOSS OF LARGE PROVIDER GROUP OR HEALTH SYSTEM

Due to our experience working with members with complex needs, we have faced the loss of providers in our markets for a variety of reasons from time to time. Small or large, the loss of a provider can have deep effects on members and caregivers. Members feel uncertain, and the key to helping them is open, pro-active communication to create awareness and plan for the transition. Transition planning and its process must focus on minimizing the disruption to members' lives to the greatest extent possible.

Our continuity of care protocols and processes and our general approach to Medicaid managed care in individual states are consistently aimed at minimizing disruption of members' care. However, situations are unique, and we retain enough local flexibility and control to tailor our response as needed in partnership with the state health agency and other key stakeholders. For instance, the closure of a large skilled nursing facility in Hawaii required a different approach from the recent bankruptcy and loss of a large health home and durable medical equipment provider in Florida. The common factor is WellCare's culture of patient-centeredness that ensures every team member working on care transitions is sensitive to members' needs first and foremost throughout the process.

Some elements to our response when facing the loss of a large provider group or health system

- **Network Adequacy and Duplication:** The most important step in this response happens long before the loss of the provider when we ensure that there is enough capacity in the network should something like this happen. Additionally, we develop contingency plans in situations where we have single source or a large-scale provider seeing a large percentage of members.
- **Care Management Engagement:** Depending on the number of members and the types of acuity, we will tier members by acuity levels and start by proactively reaching out to complex and medically needy members first. Through this process, we establish different levels of outreach and transition activities based on members' acuity level.
- **Supporting Remaining Providers:** Our provider services team will proactively reach out to all providers who could be affected by increased volume or who need updated information for referring members. This ensures the system as a whole continues to function efficiently.
- **Streamlining Utilization:** We establish a timeline for honoring existing prior authorizations from the terminating provider to the new providers and base those timelines on the needs of the system and in partnership with MLTC as appropriate. In Florida, for instance, we are honoring prior authorizations for 60 days post-transition.
- **Customer Service Engagement:** Even as we work to minimize disruption on the front-end, we prepare to assist members who contact us. To ensure quality, we create situationally appropriate

scripts for member and provider services associates and gear up our grievance teams to address issues in real-time.

- **Keeping our Partners Informed:** Our local health plan leadership will proactively communicate with MLTC, other state partners, advocates, local legislators, tribal entities, and professional associations such as Nebraska Hospital Association, Nebraska Medical Association and Leading Age Nebraska so they are well equipped to respond to member concerns.
- **Delivery of services:** Our provider services team will arrange for single case agreements even after contract termination, as appropriate and possible, to ensure members have access to medically necessary services and to support continuity of care.
- **An enterprise-wide focus:** Again, given the size and scope of the provider loss, WellCare's local health plan leadership will engage WellCare corporate resources for support as needed. In Florida, for instance, after the loss of a large provider, daily calls were held in a Command Center environment with as many as many as 40 to 50 WellCare staff members and leadership engaged to ensure that members were being cared for during this transition period.

Notifying MLTC

WellCare will comply with all MLTC provider termination notice requirements including submission of an updated network sufficiency analysis and network development plan when a significant change occurs, as defined by MLTC. We will also provide ongoing updates to the state ahead of and during the transition of members.

Coordination with Pharmacy Benefit Manager

Upon notice of the loss of a provider group, our Pharmacy Benefit Manager (PBM) will provide pharmacies advance notice that the group will no longer be in the network. WellCare's policy has been to ensure payment of pharmacy claims for non-participating providers, so the expectation is that members would not experience an access to care issue with the immediate termination of a provider group from our medical network. Members would need to see a new participating provider after they have exhausted available refills. The communication from the PBM to the pharmacy network is focused on ensuring pharmacies are assisting these impacted members.

Automated Systems and Membership Supports

We implement automated systems and membership communications guided by written policies and procedures to address any potential significant loss of a provider group. We begin with a notification to members of a significant network change. There are three letters automatically generated, and supplemented by outbound calls, to assist affected members with provider transition:

- Members assigned to the affected PCP
- Members who have seen a specialist twice in the previous six months
- Members with open authorizations who will need a transition of care

When members have questions in regard to a change in the provider network, WellCare makes several lines of communication available to them. WellCare takes pride in working with our community and member outreach teams to prepare them for member discussions and questions. In addition to the 24-hour availability of our member portal, members may contact member services, care managers or our member outreach team for assistance. Although the letter generation is an automated process, member support can require more individualized attention.

For example, at our Georgia affiliate when a large provider went out of business, we collaborated with the provider to develop a personalized letter that the provider sent to the members that listed available providers in the community. In addition, we contacted the providers listed on the letter to make sure they

had extra intake staff available who could give the member access to an immediate appointment. The member outreach team also contacted all the members the provider had seen within the previous three months and gave the member other available providers in their community and assisted with making appointments as needed.

Systems and Policies Used for Continuity of Care for Impacted Members

We have policies and procedures that dictate the continuity of care for members transitioning to alternative providers in the WellCare network, including those in an active course of treatment of an acute medical condition or an acute phase of a chronic condition. In addition, our current provider agreements require a 90 day transition of care for our members in the event of a termination.

For members in the midst of treatment for an acute medical condition or an acute phase of a chronic condition, we take the following steps:

- Members in care management are transitioned by their care managers
- We outreach to members in an active course of treatment to transition care
- Members with procedures authorized by a WellCare provider or facility can proceed with and complete the authorized course of treatment
- Care management staff identify any possible barriers that would prevent a successful transition and follow up with providers and other organizations to ensure there is no disruption of services

WellCare recognizes the criticality of physical and behavioral health co-existing conditions, especially as it pertains to pregnant members with behavioral health and/or substance use issues. Our continuity of care policies and procedures allow pregnant members to continue to receive services from their behavioral health or substance use treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.

Redeveloping the Network

When a major provider termination or loss occurs, an important objective is to redevelop the network. Our redevelopment activities typically include the following actions:

Impact Assessment and Needs Analysis

- Run Geo Access reports to determine if the termination creates a gap in access to care for our members
- Run member utilization reports to identify members who have outstanding authorizations with the terminated providers or who received care within the past six months
- Identify potential providers for recruitment to resolve gaps in access to care
- Maintain an issue log to track provider concerns and identify alternative service locations

Measure and Evaluate

- Evaluate Geo Access reports to determine the impact on the network
- Deploy provider services representatives to discuss the termination and address concerns of local providers
- Conduct network development activities to resolve gaps in access to care
- Arrange for single case agreements, telehealth, and member transportation, as necessary, to ensure members have access to medically necessary services

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

45. Describe the MCO's credentialing and re-credentialing process including:

- Ensuring that providers are enrolled in Medicaid and have a valid identification number.
- Obtaining information on ownership and control.
- Identifying excluded providers and persons convicted of crimes searches.
- Using quality and utilization measures in the recredentialing process.

(Page limit 3 pages)

CREDENTIALING AND RE-CREDENTIALING PROCESS

WellCare operates credentialing programs for our Medicaid and Medicare Advantage plans in 16 states and will perform credentialing and re-credentialing for our Heritage Health providers in strict accordance with federal, state and current NCQA Standards and Guidelines for the Accreditation of MCOs requirements as well as Section IV.I of this RFP. WellCare has established policies and procedures around all aspects of our credentialing program and will submit them to MLTC for review and approval. WellCare of Nebraska's medical director is responsible for oversight of care delivery and all quality improvement activities, including oversight of credentialing.

Our credentialing program includes:

- Comprehensive training plan to educate staff as to credentialing and re-credentialing requirements
- Provisions for monitoring and auditing compliance with standards
- Provisions for prompt response and corrective action when non-compliance is detected
- Description of the types of providers credentialed
- Methods to verify credentialing assertions, including any evidence of prior sanctions
- Prohibitions against employment or contracting with excluded providers
- Provisions to ensure enrollment in Medicaid and validate Medicaid identification number
- Provisions to obtain information on ownership and control
- Provisions to identify persons convicted of crimes
- Provisions to incorporate quality and utilization measures in the recredentialing process
- Credentialing Committee chaired by the WellCare of Nebraska medical director and comprised of participating Nebraska peer providers

Credentialing and re-credentialing is performed for every independent practitioner and organizational provider in our network. Hospital ancillary providers are not required to be independently credentialed if those providers serve our members only through the hospital. Initial credentialing is conducted prior to the effective date of the provider's contract, and re-credentialing is conducted at least every three years. WellCare will completely process credentialing applications for all provider types within 30 calendar days of receipt of a completed a credentialing application. A completed application includes all necessary documentation and attachments. This will include the loading of the provider to our provider files or the denial of the application. In the event a denial decision is recommended, the provider is notified of the credentialing committee's determination and provided with appeal rights.

Delegated Credentialing

We approve entities that have a demonstrated ability to perform high-quality and accurate credentialing of providers through a delegated agreement. Prior to approval, we conduct a pre-implementation review to verify that the entity meets or exceeds our policies and procedures. Post implementation we conduct semi-annual targeted audits of the entity's credentialing and re-credentialing processes and adherence to our

policy. The results of those audits are reported to the Credentialing Committee for review and approval. WellCare will obtain MLTC approval of all delegates and the credentialing process, including delegated components. We understand that MLTC retains final approval of our credentialing delegates and process.

Universal Credentialing Application

We will accept a Council for Affordable Quality Healthcare (CAQH) universal credentialing application form or a WellCare credentialing application. We will also accept any standardized provider credentialing form or process for applicable providers within 60 calendar days of its development or approval by the administrative simplification committee and MLTC.

Comprehensive Review

All applicants undergo a comprehensive review and verification of their education, experience, licensing and other requirements in accordance with NCQA guidelines. The credentialing process begins with the provider's completion and submission of either an electronic or paper application form. The application and all corresponding documentation are collected by our provider services and network management department and submitted into our workflow/tracking system to credentialing. Once the application is determined to be complete, a credentialing associate will review it for completeness.

Ensuring Enrollment in Medicaid and a Valid Medicaid Identification Number

We will require all of our contracted providers enroll with MLTC as an approved service provider. To expedite provider network participation, we will begin our credentialing process concurrently with a provider's Medicaid provider enrollment rather than waiting for MLTC approval of the provider's enrollment. We will verify the Medicaid enrollment with the state of Nebraska through the mechanism provided to the MCOs.

Obtaining Information on Ownership and Control

As part of our credentialing process we require each provider entity disclose information in accordance with 42 CFR 455.104. Ownership and Control disclosures are obtained for providers during initial contracting. WellCare will maintain copies of all Ownership and Control form requests and responses made and will make those request and response materials available to MLTC upon request, and advise MLTC when there is no response to a request.

Identifying Excluded Providers and Persons Convicted of a Crime

At the time of initial credentialing, we verify whether a provider has been sanctioned through the National Practitioner Data Bank (NPDB). For non-individual providers, we review the System for Award Management (SAM). The Office of Inspector General Cumulative Sanctions Report may also be accessed. State Medicaid sanctioned provider listings are also queried as available. In the event a new applicant is identified as having Medicare or Medicaid sanctions, or evidence of a conviction for defrauding Medicare or Medicaid, the applicant is advised in writing that WellCare does not accept for provider participation any applicant with current Medicare or Medicaid sanctions or violations.

On a monthly basis we check current staff, subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS)) or their equivalent, to identify excluded parties. We also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and re-credentialing. We do not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act.

Credentialing Committee

The Credentialing Committee will be chaired by the WellCare of Nebraska medical director and comprised of participating peer providers from the state of Nebraska. Providers who meet our established

"clean credentialing file" criteria are individually approved by our medical director and then presented in a list format at each meeting of the credentialing committee as opposed to being reviewed by the committee individually. If a file does not meet our established criteria for clean files, (e.g. the provider has malpractice claims, quality of care issues or past licensure sanctions) the details of the applicant's file are presented to the credentialing committee for review and recommendation. The credentialing committee holds regularly scheduled meetings every month to review applications. The credentialing committee will also convene ad-hoc meetings as necessary to accommodate large network expansions such as a new market. Providers are notified of the decision of the credentialing committee in writing and if credentialing or re-credentialing is denied are advised of their right to appeal.

Systems Capabilities

We use the Computer Assisted Credentialing Tracking Update System (CACTUS), which is an industry-leading credentialing tool, to manage inventory and information accurately and efficiently. CACTUS allows us to customize credentialing practices and generate ad-hoc reports that may be required or requested from internal or external customers.

Ongoing Monitoring

During the intervening years, providers are monitored on a routine basis. This monitoring includes review of Medicare/Medicaid Sanction Exclusion and Reinstatement reports, the List of Excluded Individuals and Entities, Medicare Opt-Out listings, System for Award Management Exclusions, professional licensing actions and internal provider performance monitoring through the collection and review of grievance and adverse event information.

Using Quality and Utilization Measures in Re-credentialing

We re-credential providers every three years. Complaints or grievances related to quality of care, access or other issues are investigated promptly through our quality improvement process. Findings are included in the provider's credentialing file along with information on corrective actions ordered and verification of implementation. Utilization management also reviews claims for the evidence of aberrant practice patterns. We rely on peer-to-peer counseling by a medical director or pharmacy director to assist providers in addressing issues resulting in member complaints and aberrant practice patterns. These monitoring activities along with the results of any individual member satisfaction surveys are reviewed as part of the re-credentialing process.

Evidence of Current Credentials

We maintain evidence of current credentials in each network provider's file. We have established processes that automate the provider maintenance processes. We currently have the technology to conduct primary source verification automatically for provider medical licenses and DEA licenses.

Special Assistance to Providers

Our Nebraska based provider services representatives will be educated about credentialing requirements as part of their new hire training. These representatives will be actively involved in the credentialing process and will work directly with providers to facilitate the credentialing process and collect missing information. Since some of these providers may be new to the credentialing process, we will put special focus on these provider types, using all resources available to get them through the process. We have successfully done this in other states.

SECTION IV.I PROVIDER NETWORK REQUIREMENTS

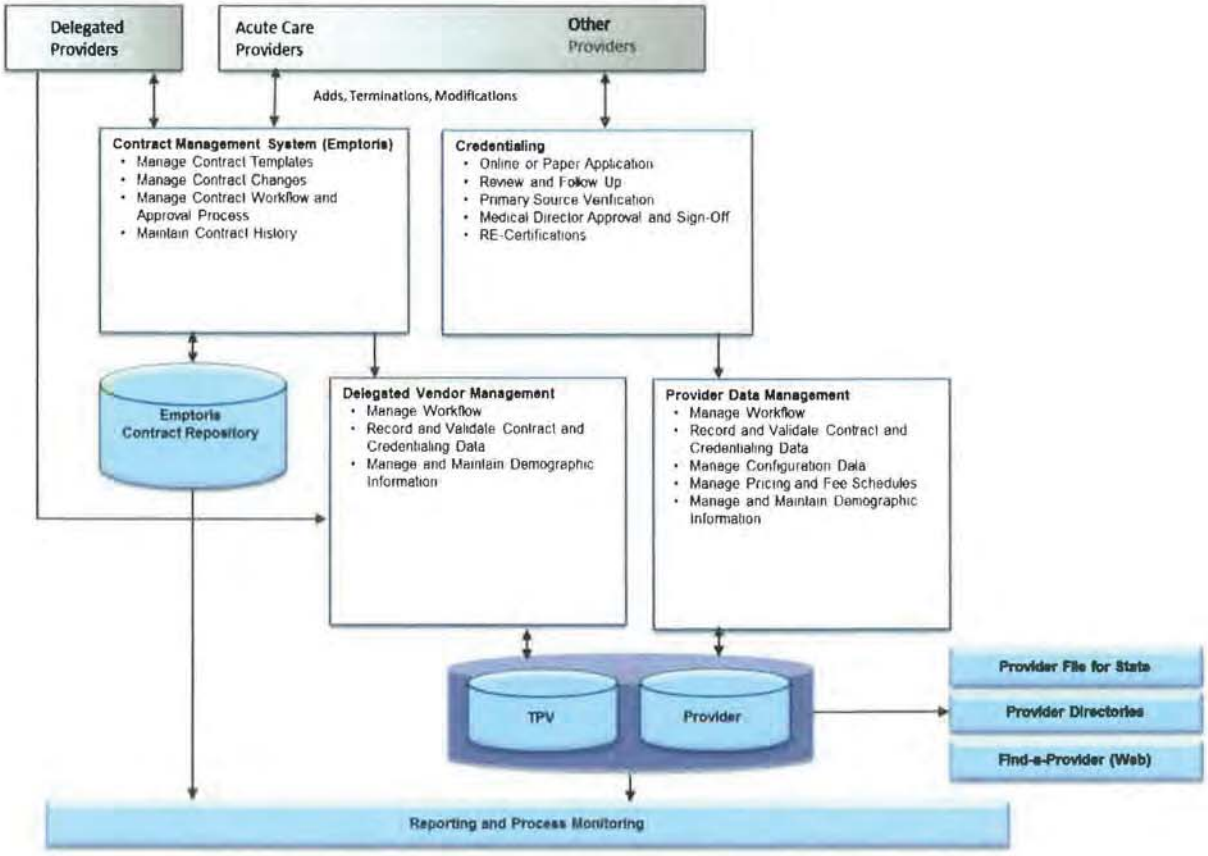
46. Explain the process the MCO will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing State and Federal identification numbers to ensure excluded providers are identified. *(Page limit 2 pages)*

WELLCARE'S PROCESS TO MAINTAIN PROVIDER FILES

WellCare's provider management applications support the crucial need to identify, contract with, and maintain productive relationships with a broad network of providers and community agencies. Our provider data file is supported by multiple departments including network integrity, provider services, contracting, credentialing and configuration. See **Figure 6** for our provider data loading process. Each step in the process includes data and quality review steps to fully support provider payment and ensure that WellCare is continually able to provide an accurate, current, and up to date provider directory to our members and providers. Examples include address verification processes to ensure physical and mailing addresses are accurate and usable for correspondence, and GeoAccess verification.

Figure 6

WellCare Provider Credentialing, Contracting and Loading Process



Data Elements in Provider File to Support Payment

WellCare's provider database includes associating the critical data elements of the national provider identifier and state Medicaid identification number to each provider entity in addition to requiring federal tax identification number information for any provider prior to making payments. These validations ensure the ability to support the routine generation of 1099 forms and data files to the Internal Revenue Service. Among the many data elements included in our provider data file are provider name, contracted services, place of service, office phone numbers, office hours of operation, emergency/after-hours provisions, professional qualifications and licensing, areas of specialty, cultural and linguistic capabilities, malpractice insurance coverage and history, and credentialing status.

WellCare Provider Databases
WellCare maintains over one million provider records in support of Medicaid and Medicare provider payments.

Based on review of reporting requirements in the RFP and Attachment 6, the data captured in WellCare's provider database supports meeting federal and MLTC reporting requirements, including items like provider termination information, network and network adequacy, appeals and grievances, and fraud reporting. Upon release of the reporting guidelines, WellCare will review the detailed requirements, identify and resolve any data collection gaps that may exist.

Excluded Providers

WellCare ensures compliance with 42 CFR 438.610, Federal Acquisition Regulation and Executive Order 12549 through mechanisms designed to prevent WellCare from having a known relationship with any debarred, suspended, excluded or otherwise ineligible party. WellCare performs monthly state and federal exclusion check reviews, including the OIG-LEIE and SAM databases, on individuals and entities contracted by WellCare, both internally and utilizing a third party vendor. Both participating and non-participating providers are tested for exclusion criteria prior to loading them into our systems for payment and on a recurring monthly basis. Individuals or entities confirmed to be debarred, suspended, excluded or otherwise ineligible are removed from contracting and no payment is made for any items or services furnished, ordered or prescribed by the individual or entity. WellCare notifies state and federal authorities as mandated by contractual and regulatory requirements.

In addition to our internal mechanisms to identify excluded parties, subcontractors themselves are contractually required to immediately notify WellCare of debarment, suspension, exclusion or any other cause for removal from federal and state health care program participation.

Provider Payment

WellCare generates all payments using electronic funds transfer (EFT) and remittances (using the 835) electronically. These transactions are submitted to our vendor PaySpan for execution. Completed transactions are returned for tracking, reconciliation and final payment verification. Providers unable or unwilling to utilize electronic formats are accommodated by PaySpan with paper documents produced from these electronic transactions or the ability to download remittance advices directly from their web portal. PaySpan is a payment card industry (PCI) compliant payment organization and independently registers providers and maintains EFT bank account information. This strategy provides additional compliance support with PCI security requirements.

SECTION IV.J PROVIDER SERVICES

47. Provide a description of the MCO's provider services program/department and how the MCO 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 MCO will form for providers to offer input regarding issues such as the MCO's service delivery, MCO/provider interactions, and potential opportunities/ innovations for improved health outcomes.
- Description of how the MCO will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP.
- Sample provider outreach methods.

(Page limit 4 pages excluding examples of outreach methods)

PARTNERING WITH OUR PROVIDERS: AN OVERVIEW OF WELLCARE PROVIDER SERVICES

WellCare was founded by physicians 30 years ago, and has consistently maintained our focus on building effective partnerships with our providers because we know they are the key to improving member health and enhancing their quality of life. Our provider engagement model is designed to aid both providers and WellCare to achieve our shared goal of improved health outcomes. The program includes the following:

- An account management structure to resolve providers' claims issues consistently and efficiently
- Personnel and tools to improve quality scores, effective utilization and operational efficiency
- Trained associates who focus on managing relationships, timely performance and issue resolution

WellCare recognizes that exceptional service for health care providers can only be achieved with true collaboration and strategic placement of field staff from various disciplines. Our integrated provider engagement model includes eight departments who collaborate to support providers in an integrated fashion. To maintain account ownership and accountability, our provider services representatives are the primary point of contact.

Field-based associates supporting our provider partnerships include:

- **Provider services representatives**: These representatives specialize by provider type and are our primary provider-facing staff. They are focused overall on partnering with and supporting providers, in conjunction with our medical director, on issues such as quality, cost and appropriate utilization. They educate providers on relevant tools, including electronic health records and our provider portal. WellCare will have sufficient provider services representatives to cover the 93 counties in Nebraska.
- **Clinical HEDIS Practice Advisors (CHPAs):** These field nurses are deployed to work with practices to improve Health Effectiveness and Data Information Set ® (HEDIS) quality measures focusing on well-child care, preventive care and addressing care gaps to ensure optimal management of chronic conditions.
- **Operations Account Representatives:** Operations accounts representatives are specialists assigned to high volume practices to provide education on billing practices and reimbursement policies, and resolve issues related to claims, reimbursement, authorizations and referrals. These account representatives are able to adjust claims in real time and on-site at the provider's office if needed.

Our field-based support also includes our Nebraska based medical director, behavioral health manager, pharmacy director, quality management coordinator, EPSDT coordinator, medical management coordinator and tribal network liaison who are available face-to-face, via telephone and email.

In addition to our main office in Lincoln, we will locate provider services staff in Welcome Rooms in key locations across the state, including Omaha, Kearney, Scottsbluff and Norfolk.

Provider Engagement Model Visits: Tools and Resources

Our provider engagement model uses proactive tools and resources to support the work of the team. Our staff is equipped with planning and provider tools for effective and efficient visits as described below.

- **Pre-visit Checklist:** Pre-visit checklists that serve as a tool to support better quality, lower costs and improved patient experience
- **Provider Summary:** Includes the primary care provider's (PCP) assigned members' care gaps and health care utilization, HEDIS quality scores, and medical economic reports
- **Issue Resolution:** Associates assist providers in resolving issues or administrative barriers such as obtaining specialty services for a member or adjusting claims real time in provider offices

Partnerships with the Provider Community

When we enter a new market, WellCare first establishes relationships with key providers and professional societies to gather their input on transformative partnerships, what has worked, what has not worked and why. An example of our focus on partnerships comes from our recent meeting with the Nebraska Association of Behavioral Health Organizations (NABHO) and various follow-up meetings with members of their board. During those meetings we discussed the behavioral health challenges in the state and possible partnerships to develop a true crisis continuum that is recovery focused and trauma informed which will meet the needs of the adult population and children, particularly those in foster care.

Examples of our partnerships in our other markets include:

- Facilitating selected telehealth services that may not otherwise be accessible to members through a partnership with Georgia Partnership for TeleHealth
- Helping a Georgia Federally Qualified Health Center build a satellite clinic to fill a primary care gap

PROVIDER HANDBOOK AND OTHER MEDIA

Our provider handbook will be specific to the Heritage Health plan and available as a searchable and downloadable electronic copy on our provider website. A printed copy of the provider handbook is available at no charge to the provider and may be requested through our toll-free line. Providers are notified of this resource during initial training and in our newsletter. In administering our program we take all necessary steps to afford our providers all rights outlined in the provider handbook. Consistent with Division of Medicaid and Long-Term Care (MLTC) requirements, our provider handbook will include the sample topics listed below.

- Description of WellCare and our corporate entity
- WellCare chronic care and disease management programs including making referrals
- Paper and electronic claims submission protocols and standards including clean and complete claim instructions and samples
- Services and benefits provided, including value-added services
- Compound prescription requirements
- Prompt payment requirements
- Emergency service responsibilities
- Prospective DUR response requirements
- MLTC standards for geographic access and appointment availability
- Provider rights and responsibilities
- WellCare grievance system policies and procedures including instructions for filing a grievance or appeal on behalf of the member
- Utilization management requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews
- Process to verify a member's enrollment
- Quality performance standards and requirements
- Clinical criteria for admission, continued stay and discharge for each covered service

- Medical necessity standards as defined by MLTC and WellCare
- Process for appealing payment and service denial decisions
- Reporting requirements for serious reportable events and reportable adverse incidents
- Practice guidelines and protocols
- How to use web-based provider services
- Use of MLTC preferred drug list
- Credentialing process and criteria
- Contact center number and hours
- PCP responsibilities
- Medical record standards
- Names and contact information of provider services staff
- Mainstreaming requirements

Our provider handbook will be updated annually to ensure program changes are included. This update will happen in consultation with MLTC and, as appropriate, our members, their families, providers and other stakeholders. Input from the Nebraska Provider Advisory Committee will be obtained as part of our handbook update. As policies and procedures change, updates will be issued by WellCare in the form of provider bulletins and will be incorporated into subsequent versions of the handbook. WellCare will notify providers of changes to the handbook through a table of revisions in the front of the handbook. Provider bulletins will be posted to our website and in the monthly provider newsletter. For material changes, we send a formal notice in accordance with the terms of our provider contracts. Providers will be alerted to provider bulletins containing changes in the provider handbook by email.

Committees for Providers to Offer Input

Nebraska network providers will serve on the following committees:

- **Clinical Advisory:** Provides input into all WellCare policies, procedures, and practices associated with care management and utilization management functions.
- **Compliance:** Assists the board in overseeing WellCare of Nebraska's regulatory compliance program, policies and procedures and compliance with our code of conduct and business ethics and related policies.
- **Credentialing:** Responsible for credentialing and re-credentialing oversight and peer review of provider quality of care/service and conduct issues.
- **Pharmacy and Therapeutics:** An advisory group of physicians and pharmacy providers responsible for recommending the adoption of, or assisting in the formulation of, broad professional policies regarding the evaluation, selection, and therapeutic use of drugs by the network providers.
- **Provider Advisory:** An advisory group of providers to ensure ongoing two-way communication between WellCare's staff and the provider network. The Behavioral Health Advisory Committee serves as a subcommittee, and behavioral health providers also sit on the larger Provider Advisory Committee.
- **Utilization Management**: Oversees all clinical quality improvement, utilization management, behavioral health and long term services and supports activities.

All committees will report to the Quality Improvement Committee, and committee representation will include a broad cross section of provider types and rural, frontier and urban providers.

Giving Local Providers a Voice: WellCare's Nebraska Provider Advisory Committee

WellCare will establish a Nebraska Provider Advisory Committee (PAC) with representation from the major provider organizations in Nebraska, individual providers, behavioral health providers, pharmacy providers, hospitals and providers who primarily serve individuals with disabilities. It is our intent to work collaboratively with our PAC and established provider organizations as we create network development and management strategies and procedures. A Behavioral Health Advisory Committee (BHAC) will provide even more specialized input to the PAC. We will work closely with the PAC to

secure input on planned initiatives and feedback on existing services. Sample discussion topics include network development and management strategies, coordination of care, provider communication needs and educational opportunities, health plan and provider experiences, health services and integrated care, operations, quality initiatives, value based purchasing tools and technology, access to care, and cultural competency. The PAC will play an active role in idea generation and decision-making as we work in partnership with the provider community.

PAC meetings will occur quarterly. Local staff will participate in the meetings including our provider services manager and medical director who will work directly with the PAC to establish methods for processing and responding to provider concerns. We will seek nominations to the PAC from WellCare staff as well as the provider community. Information about the PAC will be available on the provider website, in the handbook and in the newsletter. We will promote participation of providers by scheduling a conference call at a regular and mutually agreeable time, and by providing a monetary stipend to recognize the value of the provider's time.

Sample Provider Outreach Methods

See **Figure 1** for a sample of our provider outreach methods.

Figure 1

Heritage Health Sample Provider Outreach Methods

Outreach	Description
Provider Services Visits	General education and assistance. The Provider Summary, a dashboard with HEDIS scores and measures of provider efficiency, is the primary tool used during provider services visit.
CHPA visits	General education around the HEDIS measures and HEDIS Toolkit including measures, required documentation, quick coding tips and other information.
Provider Contact Center	Dedicated toll-free provider services telephone line available to providers for questions, to verify eligibility and obtain other services.
Provider Website and Portal	Provides a broad array of information to the provider including orientation brochures, quick reference guides and training material. (see question 49 for more information)
Provider Newsletter	Monthly provider newsletter which includes a wealth of general and Nebraska-specific information such as tips for improving patient adherence, ICD-10, and formulary updates.
Provider Tidbits	Ad hoc communications typically emailed and reinforced by provider services representatives that address current issues such as updates/changes, friendly reminders, and resource links.
Campaigns/sweeps	Campaigns are performed to emphasize a specific topic to the entire network within a very short time using all available methods.
Other routine	Orientation brochures, quick reference guides, fax blasts and web announcements

Attachments

- Attachment 47a_Provider Newsletter
- Attachment 47b_Free Online Behavioral Therapy Notice
- Attachment 47c_ADHD Guide for Children and Adolescents in Primary Care
- Attachment 47d_COBALT Tidbit

WellCare Health Plans

Introducing Online emotional health support for WellCare members

Web-based confidential care

When it comes to your patients' emotional health, we have a program that makes it easy for them to get the support they need. Access self-guided, self-paced, online programs to support them anytime and anywhere.

Programs are:

- Clinically proven
- Medication free
- Easy to use
- Long-lasting improvement

You can refer your patients now to these programs:

- RESTORE—for difficulty sleeping, 7 online sessions
- SHADE—for alcohol or substance use, 10 online sessions
- FEARFIGHTER—for anxiety, panic and phobia, 9 online sessions
- MOODCALMER—for mild to moderate depression, 4 online sessions

This is short-term, goal oriented, computerized cognitive behavioral therapy (CCBT) that focuses on problem-solving and skill building to help identify thoughts, modify beliefs and change behaviors.

Enroll patients now by going to:
wellcare.cobaltcbt.com and select "Create Account Now"

Questions?
Please call Bridget Cepalia at 860-507-1844

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SECTION IV.J PROVIDER SERVICES

48. Describe the MCO's Provider Services toll-free telephone line, including:

- How the MCO will provide a fully-staffed line between the hours of 7:00 a.m. and 8:00 p.m. CST. Monday through Friday, to address non-emergency issues and how the MCO will provide a clinical pharmacist staffed at all times during the hours of 8:00 a.m. and 8:00 p.m. CST Monday through Friday.
- How the MCO 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 MCO will accommodate services for Nebraska.
- How the MCO will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction.

(Page limit 3 pages)

BEING THERE FOR OUR PROVIDERS: WELLCARE'S INTEGRATED CONTACT CENTER APPROACH

WellCare will operate an integrated provider services contact center to respond to the needs of our Heritage Health providers. A dedicated toll-free line will be available to our providers for inquiries regarding authorizations, member eligibility, demographic changes, claims status, benefits, questions, concerns or complaints. Our provider services contact center will be staffed by highly trained agents with broad-based experience handling provider inquiries. These associates will undergo an additional four-week training program with focus on claims, eligibility, authorizations and other provider contact types specific to the Heritage Health Plan.

Integrated Contact Center

In 2014, WellCare responded to more than 1.3 million Medicaid provider calls in less than 30 seconds on average.

Our provider service line will be staffed Monday through Friday from 7:00 a.m. –8:00 p.m. Central Time, except for state holidays, to address non-emergency provider issues, and anytime for non-routine prior authorization requests and emergent provider and pharmacy issues. Clinical pharmacists will be available Monday through Friday 8:00 a.m.-8:00 p.m. Central Time for clinical questions and prior authorization processing. After normal business hours, on weekends and on established state holidays, providers have access to our automated system with recorded information about normal business hours and self-service options. Our automated system will provide information and clear instructions for callers to follow to verify enrollment for a member with an emergency or urgent medical condition. Verification is not required for emergency department services and care. Callers may also leave a message and our staff will return any message within one business day.

Our secure provider portal allows providers to process authorizations 24 hours a day, 7 days a week. Authorizations are never required for emergency care. After-hour calls into utilization management are warm transferred directly to nurses on call who addresses emergent needs. Should consultation be required with the medical director, the associate will outreach directly to the medical director by telephone to discuss the situation live.

CAREChannels, our telephone and communication platform, is designed to enhance the provider experience. Our enhanced speech recognition automated call distribution system effectively answers, routes, tracks and reports calls and inquiries. This solution allows providers to gain access to the information they seek or perform routine transactions by speaking naturally to request information about claims, authorizations, eligibility, pharmacy and prescription inquiries, including member copayments, if

applicable. These services are available 24/7. During normal business hours, callers will be connected to a live person upon indicating that option. To minimize confusion, WellCare uses a single provider services line for all providers, eliminating the need for providers to call different numbers.

First-Call Resolution: WellCare's Philosophy to Streamline Provider Engagement

Drawing on extensive experience and technologies from WellCare's corporate offices, our driving goal will be rapid, first-call resolution of all provider requests. Our contact center is operated based on established and documented policies and procedures including staffing, training, hours of operation, access and response standards, warm transfers, call escalation, data entry, reporting, performance and call quality monitoring. Contact center associates have access to mapping search engines and use these as needed to locate referral providers and assist with member transportation.

Our contact center associates also have access to our provider claims support team to facilitate real-time adjustments for simple low-dollar claims issues and a provider escalation team that time-sensitive calls can be transferred to for real-time resolution. In addition, our real time speech analytics system automatically flags a supervisor to join a provider services call when specific key words are said, allowing for proactive intervention.

Key to first-call resolution is our call management system, CAREConnects. CAREConnects is the proprietary agent desktop solution used by provider services. It is built around telephony systems, web capabilities (including chat and email) and self-service solutions. CAREConnects efficiently guides our associates through on-line scripting, workflows, and actions based on the callers' individual needs. Contact center associates have access to view electronic documentation from previous calls to assist with call resolution. Associates can respond to provider inquiries and document them through closure.

CAREConnects also helps us identify training needs and increases the effectiveness of training and quality of newly hired contact center associates more expeditiously. Analytics and reporting features allow us to identify repeat callers and the reasons for their calls as well as to identify trends and opportunities for continuous quality improvement purposes. To supplement CAREConnects, we use an extensive on-line resource library available to provider services. The library is easily searchable by key words and inquiry type.

Acknowledgement and Resolution within Timeframes

As discussed above, our provider services unit allows for the real time resolution of simple claim inquiries. These associates undergo four weeks of training on claims processing and are equipped with the resources to allow first call education and claim resolution to providers. Cases that cannot be resolved real time or require additional research are escalated to our provider escalation team to complete with resolution back to the provider within the required timeframe. All inquiries are documented in our system and should there be a situation where an inquiry cannot be resolved within three business days, we notify the provider of the expected timeframe for resolution which will not be more than 20 business days. This includes referrals from MLTC.

Location of Operations

Our Nebraska field-based associates will provide the majority of the support to our provider partners. These include provider services representatives, practice advisors, operations account representatives and CommUnity Advocates. These Nebraska associates are supplemented by our provider contact center, our provider website and our secure provider portal. In our 20 years of Medicaid experience we have developed highly competent provider services contact centers staffed by associates who are well equipped to help providers solve complex issues. These service centers offer a redundancy of qualified provider services associates which is especially important at program start when a large volume of calls is anticipated or in the event of a natural disaster. These highly trained associates are equipped to deliver exceptional provider service and first-call resolution at program start. Associates will also undergo

additional Heritage Health plan training including the geography of the state, the culture and correct pronunciation of cities, towns, and surnames.

Measuring and Monitoring Call Accuracy and Caller Satisfaction

Our approach to quality monitoring is extensive and supported through a dedicated, specialized quality assurance team as well as supervisors. Continuous evaluation occurs through our quality oversight program which includes call monitoring of at least eight calls per month per associate, secret shopper calls, real-time audits, and random sampling audits. Supervisors monitor the results for accuracy of response and telephone etiquette, to learn about individual associate strengths and weaknesses, and to identify where coaching is necessary. These efforts are supplemented with real-time listening sessions where supervisors observe the call unobtrusively. All calls are recorded and stored for 10 years.

Our quality monitoring activities are supplemented by post-call provider satisfaction surveys to assess the provider's experience with provider services. The results are analyzed for individual opportunities as well as broader organization or team opportunities for improvement.

Contact Center Monitoring to Ensure Adherence to Performance Standards

The heart of the contact center operation is our command center, located in our headquarters in Tampa, Florida. It is the control center for all provider service functions and performance. The command center provides real-time monitoring of service levels for more than 200 different skills and call types and coordinates action to achieve service targets. The command center operation also allows us to quickly and seamlessly adjust to call volumes or emergency situations so providers can easily and quickly get resolutions to their concerns or questions. See **Figure 2** for a sample of our provider services performance monitoring .

Figure 2

PROVIDER
Sample Performance Monitoring/3rd Quarter 2014

	Avg. Speed of Answer		Abandonment Rate %		Service Level		Avg. Hold Time	
	Target	Measure	Target	Measure	Target	Measure	Target	Measure
FL	<30	13	<5%	1%	90%	90%	<3 min	00:01:03
GA		25		2%	80%	84%		00:01:11
HI		18		2%	80%	88%		00:01:50
IL		21		2%	80%	86%		00:01:12
KY		27		2%	80%	82%		00:01:40
MO		22		3%	90%	89%		00:01:26
NJ		20		2%	90%	86%		00:00:50
NY		29		2%	80%	81%		00:01:23
SC		22		2%	80%	85%		00:00:51
TOTAL		21		2%		86%		00:01:16

Our contact center metrics will comply with the Heritage Health plan contact center standards including an average speed of answer (ASA) of 30 seconds and an abandonment rate of not more than five percent. We routinely meet or exceed contact center standards across multiple states. For example, in our Florida affiliate, we handled more than 300,000 provider calls in 2014 with an ASA of 18 seconds.

CommUnity Assistance Line

In addition to the provider service line, our CommUnity Assistance line is staffed by 36 CommUnity Liaisons and operates Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern Time to help provider offices and members find and access social services, including transportation, food and utilities.

SECTION IV.J PROVIDER SERVICES

49. Provide an overview of the MCO's proposed provider website, including examples of information that will be available on the website and on portals for providers.

Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website.

(Page limit 5 pages excluding sample resources, tools and materials)

REACHING PROVIDERS WHERE THEY ARE: AN OVERVIEW OF WELLCARE'S PROVIDER WEBSITE

Our Nebraska provider website will be an important communication tool to inform, educate and communicate with providers about the Heritage Health plan and WellCare. It will also offer important resources and tools for providers including tools for claim submission, claim status check, prior authorization submission and online training modules. Our policies and procedures ensure our website will be maintained with accurate and current information and we will follow all written guidelines included in Section IV.G of this Request for Proposal (RFP).

Website Adoption

In October 2015, there were approximately 320,000 visits to our provider pages.

Our Nebraska specific website will be Section 508 and HIPAA compliant as well as accessible 24/7 for network and non-network providers seeking information about the Heritage Health plan. It will also meet any other applicable privacy and security requirements. Our provider website (**Figure 3**) has both public (unsecured) and private (secured portal) environments and is accessible through an internet connected device with a browser, including smart phones.

Figure 3

Examples of Information Available

A detailed description of our provider website content follows as **Figure 4**. In addition to meeting minimum requirements, we have multiple tools to enhance the providers' experience including no-cost electronic claims submission and online training.

Figure 4: Provider Website Content

Provider Website Content	
Our dedicated provider website will include a variety of information for contracted and prospective providers, as well as the general public, that can be easily accessed without supplying log-in credentials. Available searchable information and functionality includes, but is not limited to the following:	
Searchable Provider Handbook	➢ Provider helpline information ➢ Electronic funds transfer enrollment ➢ Grievances and appeals and how to file a complaint ➢ WellCare policies and procedures ➢ Available in PDF format with searchable content
Searchable Provider Directory	➢ Find-A-Provider tool is refreshed daily with current information on network providers that include: ▪ Primary Care and specialists ▪ Urgent Care Clinics ▪ Federally Qualified Health Clinics and Rural Health Clinics ▪ Laboratories and radiology providers ▪ Behavioral health providers ▪ Hospitals ▪ Pharmacies
Pharmacy preferred drug list	➢ Online searchable drug tool
Other Helpful Information	➢ Contact information including numbers for provider service staff and prescription filing questions ➢ Quarterly provider newsletters ➢ Overview of enhancements for website functionality ➢ Limitations on provider marketing ➢ Appointment and access standards reminder ➢ Quality and health news ➢ Information and an online request for network participation ➢ Forms and documents repository ➢ Upcoming provider trainings and training manuals ➢ Clinical practice guidelines ➢ Companion and quick reference guides ➢ Frequently asked questions ➢ Member rights and responsibilities ➢ How to obtain prior authorizations or referrals including pharmacy prior authorization requirements ➢ WellCare formulary and Nebraska preferred drug list ➢ MAC pricing through pharmacy benefit manager (PBM) link ➢ MLTC bulletins, as applicable to MCO
Links to External Partners	➢ Delegated subcontractors ➢ MLTC website and other related websites ➢ WellCare Corporate

Provider Website Content	
Inquiry submission	➢ Contact us feature ➢ Allows providers to offer feedback and submit questions
What's new	➢ Identifies newly added sections
Secure Provider Portal	
Our secured environment for the provider website, requiring login and password credentials, gives our providers an opportunity to access various easy-to-use tools to obtain information and perform day-to-day tasks such as:	
Member Information	➢ Eligibility verification ➢ PCP assignment information ➢ Pharmacy utilization ➢ Inpatient admission log ➢ Membership panel assignment report ➢ Member care gaps and member care plans
Claims Support	➢ No-cost electronic claims submission via direct data entry. Includes real time HIPAA EDI compliance check supporting Strategic National Implementation Process (SNIP) data validation with error responses ➢ Check claim status ➢ Edit and rebill a claim (corrected claim)
Authorization Support	➢ Prior authorization submission ➢ Check authorization requirements ➢ Check status of prior authorization
Training	➢ Complete assigned training modules such as ▪ Provider Orientation ▪ Cultural Competency: Provider Program ▪ Secure Provider Portal Overview ▪ Interactive HEDIS Online Portal Training
Contact Form	➢ Request additional information

We will make MLTC-approved formulary changes, prior authorization requirements, clinical criteria and revisions available to providers on our website at least 30 calendar days prior to their being effective.

Provider Resources and Tools

As summarized above, WellCare has in place numerous resources and tools on the provider website and secure provider portal to streamline provider office processes. These include:

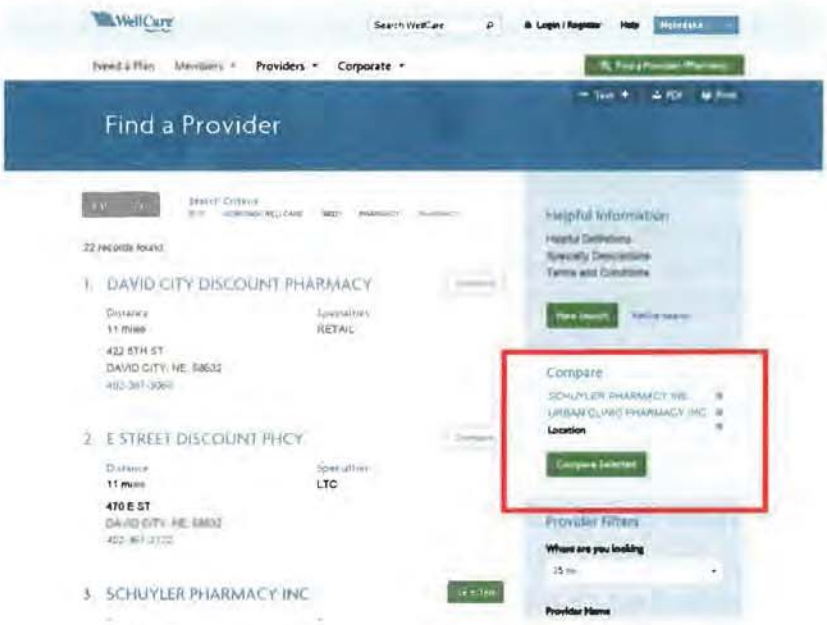
Searchable Provider Directory

Our Find-a-Provider capability makes it easy for providers, members, MLTC staff, WellCare associates and anyone else to locate network providers through an intuitive search refinement tool found on our website. Network providers, facilities and pharmacies are included with information about clinical specialization, languages spoken, disciplines and demographics. This tool allows the user to quickly refine their search based on the provider's gender, languages, accessibility considerations, provider and specialty types and distance from a user-chosen location, whether work, home, or their current location. Provider information is updated daily. Individuals do not need to login for access.

Another key feature of the Find-a-Provider tool is our comparison tool (**Figure 5**). Using the same intuitive search capability, up to three providers can be selected and compared to each other.

The initial search response provides information that includes telephone numbers, service site addresses and contact information. Additionally, distance and navigation information is readily accessible from this first search result list.

Figure 5



More detailed information is available with a simple click on the provider's name. In addition to providing the summary information, details on credentialing status and other key items such as board certification, medical group affiliations, hospital affiliations, languages spoken and ages seen.

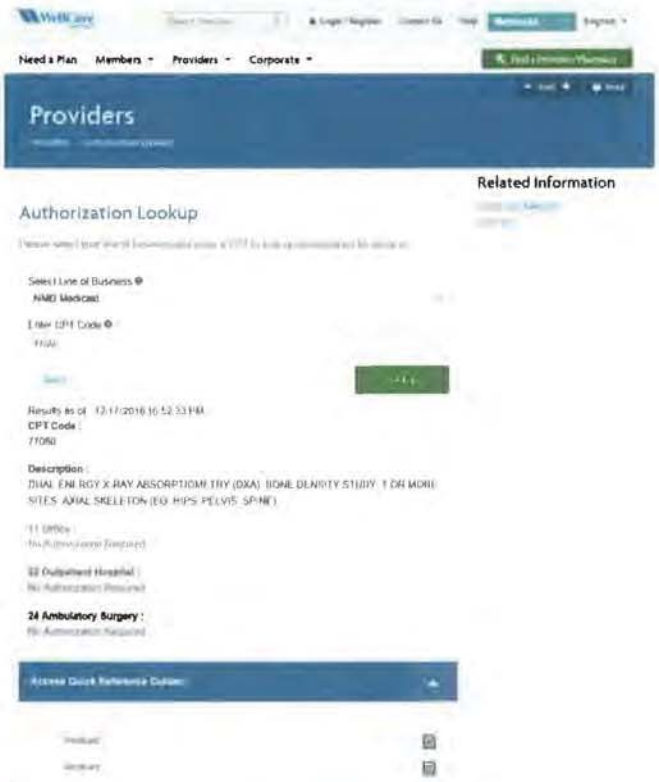
Pharmacy-Preferred Drug List

Our online searchable drug tool is available by Medicaid category of eligibility. Users can search all brand and generic drugs and view detailed drug information including actual drug name, dosage and strength, prescription drug type (brand or generic), therapeutic class, notes, and restrictions.

Provider and Member Inquiries

Figure 6

Our website has an electronic form so that members and providers can submit questions easily and securely right from their desktop or mobile device. These questions are answered by dedicated representatives who respond in the users expressed way. Electronic replies with HIPAA, payment card information or personal health information are posted to the secure portals and an email is sent to the user telling them their response is available there.



Online Authorization Submission Tool

Our online authorization submission tool (**Figure 6**) allows the submission of initial authorization and other requests.

In implementing the Heritage Health plan, WellCare will work collaboratively with MLTC and the provider community to identify program content for the provider website and additional useful resources and tools.

TECHNOLOGY USED TO ENHANCE PROVIDER WEBSITE

To ensure the consumers of our solutions are provided the maximum benefit, we obtained direct feedback from more than 750 providers and completed an independent competitive analysis to support the recent redesign of the WellCare.com website. Based on our analysis and the direct feedback, WellCare deliberately selected technology solutions that best support those needs.

To provide a uniform and consistent look and feel from any device (desktop, smartphone, tablet), the site is built using a responsive, adaptive framework which ensures our web pages are automatically rendered at the most appropriate scale for the users device, The chosen technologies that implement these latest concepts in digital user experience include **HTML5**, **CSS (Cascading Style Sheets)**, and **JavaScript**.

To ensure that timely, dynamic content is provided to users based on their individual personas (location, relationship to WellCare, and prior interactions), WellCare selected **Sitecore**, the world's leading web content management and personalization engine for .NET/Windows.

Web analytics is a core feature of our digital platform for which we are using a two-pronged technology approach. Our public site is integrated with **Google Analytics** and is complemented by Sitecore's own analytics engine called **Sitecore DMS** to provide advanced analytical and decision-making capability. To enable dynamic search of both content and custom data and leverage the latest features, search engine features such as incremental searching, progressive type-ahead, and text filtering using the **Coveo Enterprise Search** (CES) technology are embedded into the application.

Our digital investment strategy includes continuous enhancements and improvements, including the migration of our secure provider portal to this new digital platform, complete with a redesigned user experience based on extensive feedback from our provider community.

SAMPLE RESOURCES, TOOLS AND MATERIALS

We have included as attachments some of the many resources, tools, and materials found on our provider website, as detailed previously in this response.

Attachment 49a_HEDIS Online Training

Attachment 49b_Web Quick Guide

Attachment 49c_HEDIS Pediatric Quick Trips

Attachment 49d_Provider Services Quick Access Guide

SECTION IV.J PROVIDER SERVICES

50. Describe the MCO's proposed provider education and training program, including:
- A description of the training program.
- A work plan that outlines education and training activities, including frequency of office visits to conduct activities.
- A listing of the types of materials and content the MCO will distribute (include three samples of materials).
- How the MCO will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.

(page limit 5 pages, excluding sample materials)

WellCare's Integrated Approach to Provider Education and Training

WellCare recognizes the value of a well-informed network of providers, and provider communications is a priority of our senior executive and local management teams. As we implement the Heritage Health plan, we will bring to bear all necessary resources up front to ensure Nebraska providers are ready to partner with us and participate in our network. Our experience in other states demonstrates that effective, two-way provider communication improves service delivery for our members and increases provider satisfaction. We will build on our more than 20 years of experience training providers on Medicaid managed care programs throughout the country to develop Nebraska-specific programs to train, onboard and grow our network. Our activities will include:

- Extensive training curriculum to providers
- A variety of modalities and locations, accessible real time at the time and frequency needed
- Specialized training sessions by provider type including nursing homes, and behavioral health
- All training material placed on our provider website for convenient 24/7 access

Go Live Provider Onboarding Activities

We recognize that provider network preparation and education will be critical to the successful launch of the WellCare's Heritage Health plan. We have already informally been meeting with individual providers and provider groups including the Nebraska Hospital Association, the Nebraska Medical Association, the Nebraska Association of Behavioral Health Organizations, Children and Family Coalition of Nebraska, Nebraska Pharmacists Association, Health Center Association of Nebraska and the Tribal 638 Clinics/Indian Health Services. These meetings have informed our strategy for Nebraska including provider education and outreach activities.

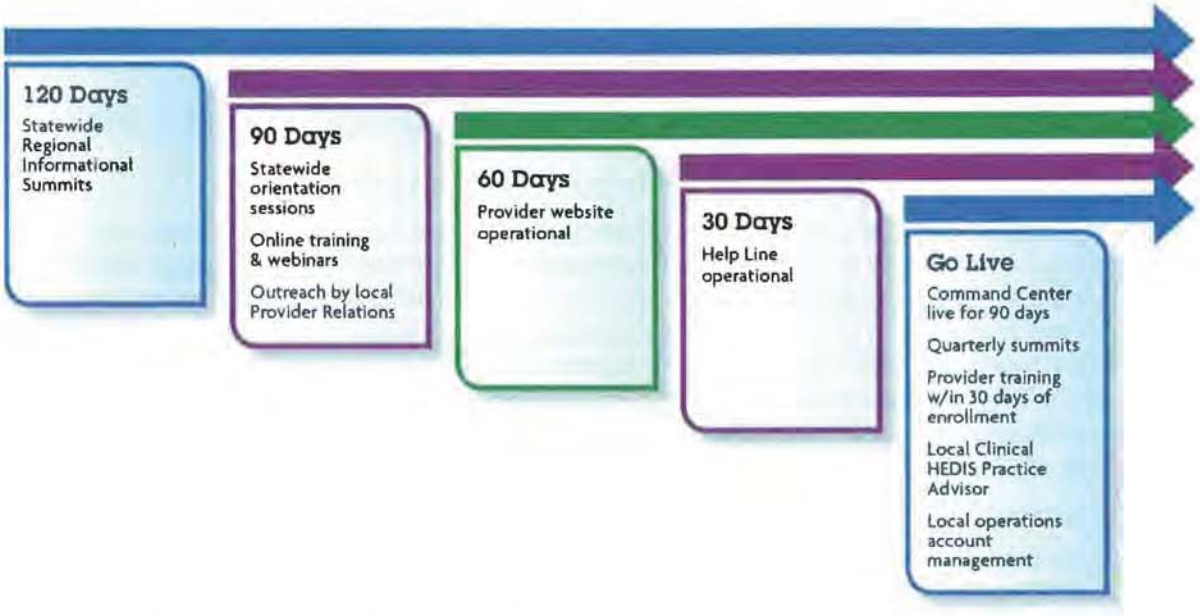
Upon award of the contract, we will continue to build on those relationships with ongoing engagement, and begin our formal provider educational initiative 120 days prior to the first enrollment date (See **Figure 7**). We will invite all providers to attend statewide orientation sessions scheduled at convenient locations throughout their area and continue these sessions through program launch and beyond. We will offer the same curriculum through multiple delivery modalities including classroom training, online, and video training, to allow as many providers as possible to participate. For providers who are unable to attend a formal training session, we will review the critical elements of the curriculum with them during an office visit. We will accommodate the training times and days of the week requested by our providers, including evenings and weekends, as needed through the implementation period.

Our delivery modalities will promote efficiency and accommodate the varied needs of our providers. In addition to provider office visits these modalities will include:

- Statewide orientation sessions in regional offices as well as at hospitals or community centers near a provider's location. Subject matter experts on-site to assist with questions and demonstrate tools.

- Web-based provider training, featuring real-time interactive courses conducted via the web. Recorded provider trainings will also be available on our website.
- Secure provider portal training offering online training modules that are available to providers 24/7. Includes provider orientation, provider portal overview and interactive HEDIS online portal modules.
- Short videos hosted on a WellCare branded YouTube channel. Videos will cover topics from completing claims forms to quick reference guidelines to help improve processes for providers.

Figure 7



Nebraska Provider Support During Go Live

WellCare will also use best practices from other WellCare implementations to facilitate the smooth transition of members into the Heritage Health plan. At program go-live and continuing for the first four weeks beyond implementation, a team of experienced provider services associates will be available in a Command Center environment to respond immediately to provider questions and facilitate the prompt resolution of any issues. Regional staff will also be deployed to key providers with anticipated large member volume for onsite provider support.

Initial Training

For newly contracted providers, our provider services department sends a welcome letter that introduces our website and provider portal. The provider services representative follows this with an introductory phone call to make initial training available within 30 calendar days to the provider, whether face-to-face, telephonic, or through web-based training. Initial training includes digital solution registration and website capabilities, access standards and audits, HEDIS quality reports, review of the Medicaid Quick Reference Guide, Heritage Health plan requirements, authorizations, claims, appropriate utilization of emergency department services, behavioral health emergencies, identifying the special needs of the member (including the LTSS populations), and limitations on provider marketing. The provider services representative follows up with the practice two to three weeks after the scheduled orientation to review and answer any questions. The provider services representative also conducts specialized training and education for nursing facilities regarding billing procedures when a member transitions from a skilled to a custodial level of care.

Providers New to Integrated Managed Care contracts

WellCare understands that many of the providers will be new to integrated managed care and some will be moving from Medicaid or Medicare only or carve-out arrangements. To support these providers we will develop and offer specialized initial and ongoing training on billing procedures, authorization requests, and other processes that will be new to these providers. Specialized training will also be developed for behavioral health providers and pharmacists. We will notify MLTC of these sessions and welcome their attendance.

Ongoing Training

Providers will receive ongoing training and education throughout the duration of this contract through the following activities:

- Online training available on the provider website, website articles and self-study programs
- Onsite visit training conducted by provider services representatives and regional practice advisors
- Webcasts that allow the opportunity to interact and ask questions
- Periodic amendments to the provider manual
- Provider newsletter

Examples of ongoing training topics include alcohol and substance use screening, enrollment and credentialing processes, and claims submission and payment processes.

Provider Forums

Following best practices from our other Medicaid markets, we will hold statewide provider forums to foster relationships with local staff members and create the opportunity for providers to ask questions and have open, honest dialogue on their experience with us. We will conduct these forums quarterly in regional venues across the state, and all supporting documents and follow-up questions and answers will be made available on our provider website. These forums will be open to all providers and facilitated by our Nebraska CEO or designee. We will continue to meet with Nebraska provider organizations and individual providers on a regular basis to obtain their input. Additionally, we have formal processes, such as the Provider Advisory Committee, to ensure robust facilitation of provider engagement and input. To facilitate process improvement, information discussed during the forums and association meetings will be made available to our executive management and MLTC.

WORK PLAN OUTLINING EDUCATION AND TRAINING ACTIVITIES

Our work plan (**Figure 8**) outlines educational targets, education and training activities and staff members providing the education and training. WellCare will submit a copy of the provider training handbook and training schedule to MLTC for review and approval at least 90 days prior to contract start date. Any changes to the handbook will be submitted to MLTC at least 45 calendar days prior to scheduled changes and dissemination of such changes. Documentation of training sessions and attendance will be available to MLTC upon request.

Figure 8

PROVIDER EDUCATION AND TRAINING WORK PLAN			
Activity	**Frequency and Format**	**Staff**	**Target Audience**
Initial Orientation	Within 30 days of receipt of welcome letter and as requested; available in person, telephonic, or on secure provider portal	Provider services representatives	All network providers
Ongoing Training Through Provider	Up to 18 office visits or telephonic meetings per year	Provider services representatives	All provider sites with frequency of scheduled

Provider Education and Training Work Plan			
Activity	**Frequency and Format**	**Staff**	**Target Audience**
Engagement Model			visits/interactions driven by volume of members served; and ad hoc as needed/appropriate
Pharmacy Network Improvement Program	As needed office visits or telephonic meetings, total of approximately 25 education encounters statewide per month	Pharmacy Director	PCPs, specialists, and pharmacies
HEDIS Measures	Up to 4 office visits per year	Clinical HEDIS practice advisors	PCPs serving 80% of membership; others on request
Cultural Competency	Required annually	Module available on secure provider portal	All network providers and office staff
Electronic Claims Adoption	Dedicated team to assist providers with the implementation of electronic claims transactions	Dedicated EDI support team	All network providers
Provider Forums	Quarterly in venues across the state	Lead by CEO or designee	All network providers
Providers New to Managed Care	Specialized training at program start and as needed	Provider claims educator/operations account representative	Providers transitioning from fee-for-service or carve-out arrangements
Nursing Facility training	Specialized training at program start and as needed	Provider claims educator/operations account representative	Nursing facilities
Targeted Group Education	As needed or requested	Faculty dependent on content covered	Provider type dependent on topic

Listing of Materials and Content

WellCare makes the materials shown in **Figure 9** available to providers through the provider education and training programs described above. Three samples of material are included as attachments.

Figure 9

Education and Training Material and Content	
Name	**Content**
Authorizations	➢ Guideline on authorization process
Behavioral Health Program	➢ Medication reference guide, billing resources, instructions for outpatient service requests, clinical coverage guidelines
Billing Guidelines	➢ Billing resources for specific services including EPSDT services
Claims Companion Guides	➢ Detailed instructions on claim submissions
Clinical Coverage Guidelines	➢ Evidence-based guidelines detailing the medical necessity of procedures or technology
Clinical Practice Guidelines	➢ Best-practice recommendations
Cultural Competency	➢ Materials and training on the secure provider portal

Education and Training Material and Content	
Name	**Content**
Electronic Funds Transfer	➢ Quick guide on how to enroll in electronic funds transfer (EFT)
Provider Responsibilities	➢ Brochure specific to educating providers on their responsibilities
Medical Management	➢ Brochure on key objectives of our medical management program
Disease Management	➢ Brochure outlining disease management programs and how to enroll a member
Prenatal Program	➢ Description of prenatal benefits and guidelines
Fraud and Abuse	➢ Examples of fraud and abuse and how to report it
Job Aids (How to Guides)	➢ Coordination of benefits, appointment timeliness standards, website registration, corrected or voided claims, quick access to provider services
Pharmacy Reports	➢ Pharmacy utilization data to facilitate quality and cost discussions
Pharmacy Services	➢ Preferred drug list and authorization, determination and appeal procedures
Planning for Healthy Babies	➢ Website training on family planning services
Provider Handbook	➢ Encompasses all aspects of providing care to members
Provider Newsletters	➢ Includes articles to educate providers on various services, programs, benefits
Provider Orientation	➢ Orientation program for newly contracted WellCare providers
Provider Resource Guide	➢ Summary of instructions for web portal, authorizations, claims submissions, EFT, appeals, disputes, among others
Provider Summary	➢ Individual provider summary containing member gaps in care, health care utilization, HEDIS quality scores and other measures
Provider Website and Portal	➢ Depository for provider education, training material and provider tools
Quality Tools	➢ HEDIS resource guide; Care coordination: Provider tips
Quick Reference Guide	➢ Basic information and guidelines for providers

Evaluating Usefulness and Using Feedback

Some of our most successful programs were developed from provider input. For example, providers requested clinical assistance in improving HEDIS® quality measures. We recognized the value of having nurses work with providers and made an investment by adding practice advisors to field staff.

WellCare solicits provider feedback on education and training through several mechanisms:

- Annual survey asking providers to rate the quality of the provider on-boarding orientation, on-site education and technical assistance, training and educational sessions, provider tools including the website, and the quality of written communications, policy bulletins and manuals.
- Evaluation cards obtained directly after an education and training session.
- Input from individual providers is solicited during outreach activities
- Survey form on provider website rating the value of their provider services visit
- Provider Advisory Committee and other committees with provider membership

Attachments

Attachment 50a_Provider Resource Guide
Attachment 50b_Provider Quick Reference Guide
Attachment 50c_Provider Orientation

Important Telephone Numbers

Provider Services **1-866-231-1821**
Eligibility Verification, Provider Complaints, Translation, Transportation Services and Utilization Management

TTY Services **1-877-247-6272**

Care and Disease Management Referrals **1-866-635-7045**
Care Management Referrals GA.CM@WellCare.com

Nurse Advice Line **1-800-919-8807**
Members may call this number to speak with a nurse 24 hours a day, 7 days a week.

Risk Management
WellCare Fraud, Waste and Abuse Hotline **1-866-678-8355**
Georgia Medicaid Program Integrity **1-800-533-0686**

Provider Resource Guide

Claim Submissions

Provider Services **1-866-231-1821**
Questions related to claim submissions

For EDI questions and assistance, please contact our EDI team who will help identify, test and correct any issues: EDI-Master@wellcare.com

Preferred EDI Partner	**EDI Payer ID**	
RelayHealth (McKesson)	14163	**1-877-411-7271**
Encounter Data Submissions	59354	

WellCare follows the Centers for Medicare and Medicaid Services' (CMS) guidelines for paper claim submissions. Since Oct. 28, 2010, **WellCare accepts only the original red claim form for claim and encounter submissions. WellCare does not accept handwritten, faxed or replicated claim forms.**

Claim forms and guidelines may be found on our website at georgia.wellcare.com/provider/claimsupdates

Mail paper claim submissions to:

WellCare Health Plans, Inc.
Claims Department
P.O. Box 31224
Tampa, FL 33631-3224

Claim Payment Disputes

The claim payment dispute process is designed to address claims when there is disagreement regarding reimbursement. Claim payment disputes must be submitted to WellCare in writing within 90 days of the date of denial on the EOP.

Mail or fax the written claim payment dispute and documentation to:

WellCare Health Plans, Inc. **Fax 1-877-277-1808**
Attn: Georgia Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370

Claims Payment Policy Disputes

The Claims Payment Policy Department has created a new mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy related issues (EOP Codes beginning with CEXXX, IHXXX, MKXXX or PDXXX) must be submitted to WellCare in writing within 90 days of the date of denial on the EOP.

Mail or fax all disputes related to payment policy issues to:

WellCare Health Plans, Inc. **Fax 1-877-277-1808**
Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426

Appeals (Medical)

Providers may seek an appeal through the Appeals Department within 30 calendar days of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient documentation or late notification.

WellCare Health Plans, Inc. **Fax 1-866-201-0657**
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Grievances

Member grievances may be filed orally by contacting Customer Service or submitted via fax or mail. Providers may also file a grievance on behalf of the member with the member's written consent. Mail or fax member grievances to:

WellCare Health Plans, Inc. **Fax 1-866-388-1769**
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

Non-Medicare Member Appointment of Representative Statement

Pharmacy Services

Pharmacy Services **1-866-269-5251**
Including after-hours and weekends (**Catamaran**)

	Rx BIN	Rx PCN	Rx GRP
Georgia Medicaid	603286	01410000	726257
Georgia Family Planning	603286	01410000	736257

Exactus™ Pharmacy Solutions **1-866-458-9246**
exactus@wellcare.com **TTY 1-866-507-6135**
Fax 1-866-458-9245

Medication Appeals **Fax 1-888-865-6531**

Mail medication appeal forms with supporting documentation to:

WellCare Health Plans, Inc.
Attn: Pharmacy Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398

Medication appeals may also be initiated by calling Provider Services. Please note that all appeals filed orally also require a signed, written appeal.

PDL Inclusions
To request consideration for inclusion of a drug in WellCare's PDL, providers may write WellCare explaining the medical justification.

WellCare Health Plans Clinical Pharmacy Department
Director of Formulary Services
Pharmacy and Therapeutics Committee
P.O. Box 31577
Tampa, FL 33631-3577

Coverage Determination Requests **Fax 1-866-455-6558**

Submit a Coverage Determination Request Form for:

- Drugs not listed on the Preferred Drug List (PDL)
- Drugs listed on the PDL with a Prior Authorization (PA)
- Duplication of Therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits (QL)
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Drugs that have an age limit (AL)
- Brand name drugs when an equivalent generic exists
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate

Web-based information:
georgia.wellcare.com/provider/pharmacyservices

- Pharmacy Services Overview
- WellCare of Georgia Preferred Drug List (PDL)
- Authorization Lookup Tool
- Participating Pharmacies
- Pharmacy Services Forms

Behavioral Health

Urgent Authorizations and Provider Services **1-800-424-5412**

Outpatient Authorization Request Submissions **Fax 1-888-871-0590**
Inpatient Hospitalization Clinical Submissions **Fax 1-888-361-6574**

- Emergency behavioral health services do not require authorization. Inpatient admission notification is required on the next business day following admission.
- Inpatient concurrent review is done telephonically or via fax. Psychological testing requests are to be submitted via fax. All other levels of care requiring registration, including outpatient services, can be submitted online. Outpatient authorization and concurrent review is done via fax.

CareCore National Programs

CareCore National is our in-network vendor for the following programs: Advanced Radiology, Cardiology, Lab Management, Pain Management and Sleep Diagnostics.

Contact CareCore for all ***authorization-related*** submissions for the services listed above rendered in outpatient places of service.
Please click on the hyperlinks above for a listing of the specific services and related criteria included in the CareCore programs.

Urgent Authorizations and Provider Services **1-888-333-8641**
Authorization Request Submissions **Fax 1-866-896-2152**

Web submissions may be done via the CareCore Provider Web Portal. A searchable Authorization Lookup and Eligibility Tool is also available online.

Contracted Networks

Vision – Optometry and Ophthalmology **1-866-522-5923**
Avesis

Dental Services – Avesis **1-800-231-0979**

Facility (e.g., hospital or ambulatory surgery center) and anesthesia claims should still be submitted directly to WellCare for reimbursement.

Transportation Non-Emergency Transportation (NET)
Non-emergency transportation is a benefit offered by Georgia Department of Community Health. Please click on the link above for information about the program, including contact information for the transportation vendors.

Outpatient Physical, Occupational and Speech Therapy Services will be handled by:
Therapy Network of Georgia Phone **1-855-825-7818** Fax **1-855-597-2697**

Prior Authorization (PA) Requirements

This WellCare PA list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. Authorization changes are denoted by a Þ symbol for easy identification. Requirements that have been edited for clarification only are denoted with a ⓘ symbol.

All services rendered by nonparticipating providers and facilities require authorization. Primary care physicians must refer members to participating specialists. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered.

A searchable Authorization Lookup Tool is available on our website at: georgia.wellcare.com/auth_lookup.

WELLCARE'S PRIOR AUTHORIZATION (PA) LIST:

***Urgent* Authorization Requests and Admission Notifications – Call 1-866-231-1821 and follow the prompts.**

- Notify us of unplanned inpatient hospital admissions **by the next business day following admission** (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information – by the next business day.
- Outpatient authorizations may be requested by phone for urgent and time-sensitive services when warranted by the member's condition. Please have **CPT and ICD-9 codes** available. Standard authorization requests may be submitted online or via fax using the numbers listed below.

Place-of-service codes (POS) are specified for some services.*

***Place of Service Codes**

11 – Office	31 – Skilled Nursing Facility	65 – End Stage Renal Disease Treatment Facility
12 – Home	32 – Nursing Facility	71 – Public Health Clinic
20 – Urgent Care Facility	33 – Custodial Care Facility	72 – Rural Health Clinic
21 – Inpatient Hospital	49 – Independent Clinic	81 – Independent Laboratory
22 – Outpatient Hospital	50 – Federally Qualified Health Center	
23 – Emergency Room	61 – Comprehensive Inpatient Rehabilitation Facility	
24 – Ambulatory Surgery Center	62 – Comprehensive Outpatient Rehabilitation Facility	

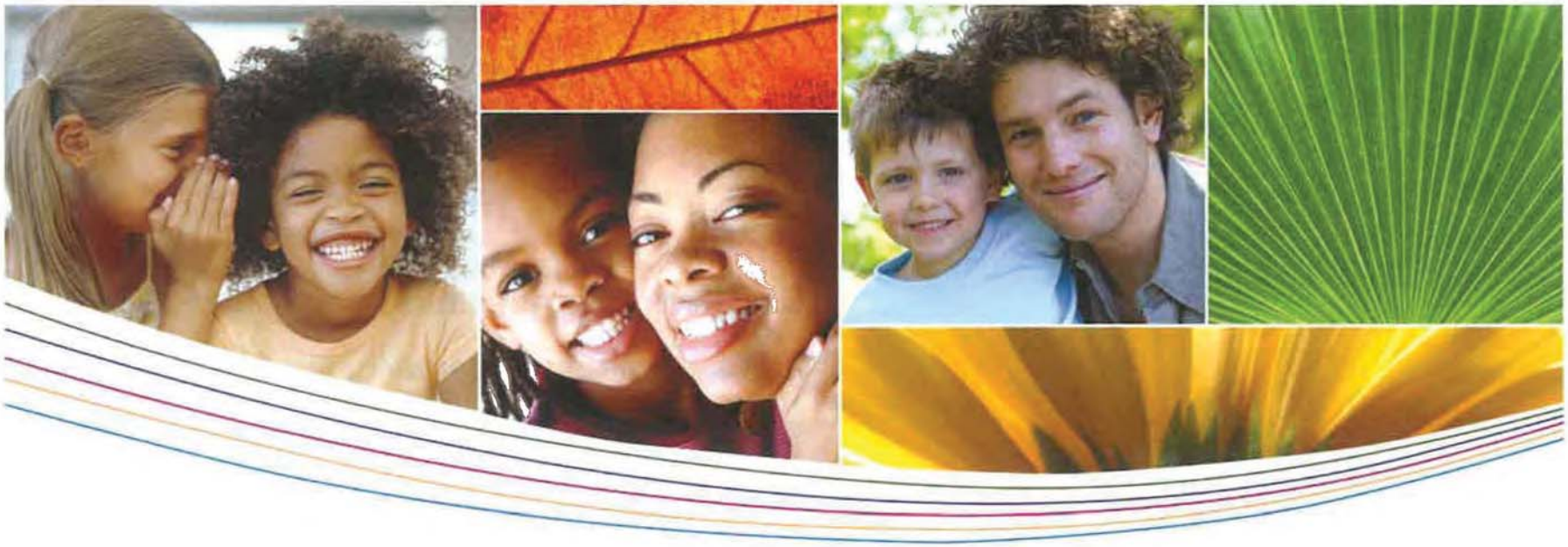
PROCEDURES and SERVICES Þ = New or changed requirement ⓘ = Clarification of current requirement	Authorization Required	No Authorization Required	Comments
	DME Services	**Fax 1-877-431-8859**	
Durable Medical Equipment Purchases and Rentals	X		All DME rentals require authorization. DME purchase items reimbursed at OR below $250 per line item do NOT require authorization.
Hearing Aids and Devices		X	Contact Provider Services regarding benefit limitations.
Orthotics and Prosthetics	X		Purchase items reimbursed at OR below $500 per line item do NOT require authorization.
	Home Health Services	**Fax 1-866-886-4321**	
Home Health Care Services	X		
	Inpatient Services	**Fax 1-877-431-8860**	
Acute Behavioral Health	X		
Alcohol and Substance Abuse Admissions	X		
Crisis Stabilization Services	See Comments	See Comments	Please reference Prior Authorization Grid
Elective Inpatient Admissions (21)*	X		Clinical updates required for continued length of stay.
Electroconvulsive Therapy (ECT)	X		
Emergency Behavioral Health Services (23)*		X	
Emergent Care Services (23)*		X	
Emergency Transportation		X	
Inpatient Hospital Admissions (21)*	X		Clinical updates required for continued length of stay.

PROCEDURES and SERVICES = New or changed requirement = Clarification of current requirement	Authorization Required	No Authorization Required	Comments
Long-Term Acute Care Hospital (LTACH) Admissions	X		Refer to Clinical Coverage Guidelines
NICU/Sick Baby Admissions	X		Notification required by the next business day following admission. Clinical updates required for continued length of stay.
Observation Stays (22)*	See Comments	See Comments	Observation services will not require authorization; however, preplanned procedures will be subject to outpatient authorization requirements. Authorization Lookup Tool Clinical updates required for continued length of stay.
Rehabilitation Facility Admissions (61 & 62)*	X		Clinical updates required for continued length of stay.
Residential Treatment	X		
Skilled Nursing Facility Admissions (31)*	X		Clinical updates required for continued length of stay.
Outpatient Services		**Fax 1-866-455-6487**	
Advanced Radiology Services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, OB Ultrasounds, PET & SPECT Scans	X		Contact CareCore National for authorization: CareCore Provider Web Portal Phone: **1-888-333-8641** No authorization required for the initial 3 OB ultrasounds: Advanced Radiology Program Criteria
Ambulatory Surgery Center Services (24)*	Please see Authorization Lookup Tool		Authorization Lookup Tool
Assertive Community Treatment (ACT)	X		
Behavioral Health Services	See Comments	See Comments	• Some behavioral health outpatient services require prior authorization. Please see Prior Authorization Grid. • Some services may require annual registration. Please refer to the BH Initial Service Request Form.
Cardiology Services: Cardiac Imaging, Cardiac Catheterization, Diagnostic Cardiac Procedures and Echo Stress Tests	X		Contact CareCore National for authorization: CareCore Provider Web Portal Phone: **1-888-333-8641** Cardiology Program Criteria
Community Mental Health Services	X		
Cytogenetic, Reproductive and Molecular Diagnostic Laboratory Testing *Note: Some tests are handled by CareCore. Please refer to Lab Management section below as well.*	X		Refer to Clinical Coverage Guidelines
Dialysis	Please see Authorization Lookup Tool		Authorization Lookup Tool

PROCEDURES and SERVICES = New or changed requirement = Clarification of current requirement	Authorization Required	No Authorization Required	Comments
Domiciliary, Rest Home and Custodial Care Admissions	X		
Electroconvulsive Therapy (ECT)	X		
Hospice Care Services		X	
Intensive Outpatient Program (IOP)	X		
Laboratory (Routine) Services (11, 22 & 81)*		X	Testing must be consistent with CLIA guidelines.
Laboratory Management (Certain Molecular and Genetic Tests)	X		Contact CareCore National for authorization: CareCore Provider Web Portal Phone: **1-888-333-8641** WellCare Lab Management Criteria
New Technology, Investigational or Experimental Procedures	X		Refer to Clinical Coverage Guidelines
Office Procedures (11)*	Please see Authorization Lookup Tool		Authorization Lookup Tool
Ophthalmology Procedures	Please see Authorization Lookup Tool		Authorization Lookup Tool
Outpatient Hospital Procedures (22)*	Please see Authorization Lookup Tool		Authorization Lookup Tool
Pain Management Services	X		Contact CareCore National for authorization: CareCore Provider Web Portal Phone: **1-888-333-8641** Pain Management Program Criteria
Partial Hospitalization Program (PHP)	X		
Pharmacological Management		X	
Psychological Testing	X		
Psychotherapy	X		
Radiology Anesthesia		X	Applicable CPT code range: 01916–01933
Radiology (Routine) Services (11, 22 & 24)*	Please see Authorization Lookup Tool		Authorization Lookup Tool
Respiratory Therapy Services	Please see Authorization Lookup Tool		Authorization Lookup Tool
Routine Primary Care Services (11 only)*	X		Pertains to services rendered in the office setting by a general and/or family practice provider, OB/GYN, internal medicine specialist and/or pediatrician

PROCEDURES and SERVICES = New or changed requirement = Clarification of current requirement	Authorization Required	No Authorization Required	Comments
Sleep Diagnostics	X		Contact CareCore National for authorization: CareCore Provider Web Portal Phone Number **1-888-333-8641** Sleep Diagnostics Program Criteria
Sterilizations		X	Informed Consent for Voluntary Sterilization Required
Termination of Pregnancy	Please see Authorization Lookup Tool		Certificate of Medical Necessity Required (DMA-311) for Payment
Urgent Care Services (20)*		X	
Prenatal Notifications		**Fax 1-877-647-7475**	
Obstetric Global Services		X	Pregnancy Notification Form
Skilled Therapy Services		**Fax 1-855-597-2697**	
Occupational, Physical and Speech Therapy Services (11, 12, 22 & 62)*	See Comments		**Please contact Therapy Network of Georgia for all outpatient occupational, physical and speech therapy requests.** Phone: **1-855-825-7818** Fax: **1-855-597-2697**

Proudly Serving *Georgia Families*® and *PeachCare for Kids*® members.



Provider Orientation

WellCare of Kentucky

WellCare®

State of Nebraska RFP Number 5151 Z1
Full-risk, Capitated Medicaid Managed Care Program for
Physical Health, Behavioral Health, and Pharmacy Services

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About WellCare

- WellCare Health Plans, Inc. is a family of health plans that works with physicians and other healthcare professionals to provide our members with quality care
- WellCare has over 20 years experience, and is the leading provider of government sponsored health plans such as Medicare, Medicaid, State Children's Health Insurance Program and others
- WellCare is among the largest Medicaid and Medicare only contractor in the nation with approximately 2.2 million members as of December 31, 2010.
- Effective July 7, 2011, WellCare has contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the "Department") to provide Medicaid and Children's Health Insurance Plan (CHIP) managed care services in seven (7) of eight (8) of the state's regions beginning November 1, 2011.

Benefits of Partnership

When you join WellCare, you gain…

- Local market focus – dedicated staff to serve providers in your communities
- Prompt provider payment – receiving claims electronically, processing claims rapidly
- Quality improvement program – patient-focused with an emphasis on preventive care
- Diverse network – selection of experienced and qualified providers who offer multilingual capabilities and cultural competency

Program Overview

- Eligibility for Kentucky's Medicaid program is solely determined by the Kentucky Department for Medicaid Services. Upon determination of eligibility, Kentucky Medicaid recipients will be enrolled with a Medicaid Managed Care plan, provided the following conditions are met:

  - The individual must reside within a Medicaid Managed Care Region
  - The individual must qualify to receive Medicaid assistance under one of the aid categories defined by the Department including, but not limited to:
    - Temporary Assistance to Needy Families (TANF)
    - Aged, blind and disabled (ABD)
      - Medicaid only; or
      - Receiving State Supplementation or Supplemental Security Income (SSI)
    - Poverty level pregnant women and children including presumptive eligibility

- For more information on Medicaid assistance, refer to the Kentucky Department for Medicaid Services at http://chfs.ky.gov/dms/.

WellCare Resources

- Providers have access to a variety of easy-to-use reference materials at **www.kentucky.wellcare.com**, including:
  - Resource Guides related to claims, authorizations, EFT and how to contact us
  - Provider Manuals
  - Clinical Practice and Clinical Coverage Guidelines
  - Provider & Pharmacy lookup
  - Quick Reference Guides provide contact information for specific departments and authorization information
  - Provider Training
- By registering for WellCare's Provider Portal, providers have access to member eligibility and co-pay information, authorization requests, claims status and inquiry, a provider inbox to receive specific messages from WellCare and provider training.
- Provider Relations representatives are available to assist in many requests for participating WellCare providers. Contact your local market office for assistance.

Provider Responsibilities

- All participating providers are responsible for adhering to the Participation Agreement and the Provider Manual.
- The Provider Manual supplements the Agreement and provides information such as:
  - Credentialing and Re-Credentialing requirements
  - Access and availability, including after-hours coverage
  - Safeguarding member confidentiality in compliance with HIPAA
  - Medical records requirements such as record retention timeframes and Advance Directive & Living Wills documentation
  - Mandatory participation in Quality Improvement projects and medical record review activities such as HEDIS® and the Department's External Quality Review Organizations (EQRO)
  - Assisting members with special health care needs, including mental, developmental and physical disabilities and/or environmental risk factors
  - Adhering to WellCare's compliance requirements
- For more information on Provider rights and responsibilities, refer to the Provider Manual.

Member Rights

- Member rights are outlined in the Member Handbooks, which are mailed to all newly enrolled members.

- Member rights include, but are not limited to, the right to:
  - Be treated with fairness, respect and dignity
  - Have the availability of language designated materials, hearing-impaired interpreter and sign language services
  - To make complaints about WellCare or the care provided
  - To appeal medical or administrative decisions WellCare has made by using the grievance process
  - A Women's Health Specialist for female members

- For more information on Member Rights, refer to the Provider Manual.

Member Responsibilities

Members are responsible for:

- Telling their PCP and other health care providers that they are enrolled in WellCare.
- Providing their PCP and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their providers agree upon.
- Becoming familiar with their benefit coverage and the rules they must follow to get care as a member.
- Informing WellCare if they have any other health insurance coverage.
- Paying their plan premiums and any co-payments or coinsurance.
- Informing WellCare about their concerns, problems or suggestions by calling Customer Service.

❑ For more information on Member Rights, refer to the Provider Manual.

WellCare's Compliance Program

- All providers, including provider employees and sub-contractors, their employees, and delegated entities are required to comply with WellCare compliance program requirements.

- WellCare's compliance requirements include, but are not limited to, the following:
  - Provider Training Requirements
  - Limitations on Provider Marketing
  - Code of Conduct and Business Ethics
  - Cultural Competency and sensitivity
  - Fraud, Waste and Abuse
  - Americans with Disabilities Act (ADA)

- For more information on WellCare's Compliance program, refer to the Provider Manual.

Covered Services

- Covered Services currently provided to WellCare's Kentucky Medicaid members include, but are not limited to:
  - Behavioral Health Services
  - Dental Services
  - Early and Periodic Screening, Diagnosis & Treatment (EPSDT)
  - Family Planning
  - Inpatient Services
  - Outpatient Services
  - Pharmacy Services
- Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.
- For more information on Covered Services, refer to the WellCare Provider Manual. Or you may access the Department's administrative regulations, 907 KAR, online at http://www.lrc.ky.gov/kar/TITLE907.HTM.

Covered Services - EPSDT

- Providers will be sent a monthly membership list which specifies the health assessment for eligible children who have not had an encounter within 120 days of joining the plan or are not in compliance with the EPSDT Program.
- Any provider who provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening service are responsible for:
  - Monitoring, tracking and following up with members:
    - Who have not had a health assessment screening
    - Who miss appointments to assist them in obtaining an appointment
    - To ensure they receive the necessary medical services
  - Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment.
  - Assisting members with transition to other appropriate care for children who age-out of EPSDT services.
- The Provider's compliance with member monitoring, tracking and follow-up, will be assessed through random Medical Record Review audits conducted by the WellCare Quality Improvement Department and corrective action plans will be required for providers who are below 80 percent compliance with all elements of the review.
- For more information on EPSDT Covered Services or the periodicity schedule, refer to the Provider Manual and the Pediatric Preventive Health Care Guidelines at www.kentucky.wellcare.com. Or for more information on the Department's administrative regulations, visit the Department's website at http://chfs.ky.gov/dms/.

Behavioral Health

WellCare

- ❑ All provisions contained within the manual are applicable to medical and behavioral health providers unless otherwise noted in the *Behavioral Health* section of the Provider Manual.
- ❑ Coordination and continuity of care between behavioral health care providers and medical care providers is critical to positively influencing member outcomes.
- ❑ PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may only provide physical health care services if they are licensed to do so.
- ❑ Behavioral health providers are required to:
  - Use the DSM-IV multi-axial classification when assessing member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member's medical record;
  - Contact the member within twenty-four (24) hours of a missed appointment to reschedule the missed appointment; and
  - Submit, with the member's or member's legal guardian's consent, a summary report of the member's behavioral health status quarterly, at a minimum, to the PCP.
- ❑ All members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge, and the outpatient treatment must occur within seven (7) days from the date of discharge.
- ❑ For more information on behavioral health, refer to the Provider Manual and the Quick Reference Guide.

Pharmacy

WellCare

- To ensure members receive the most out of their pharmacy benefit, please consider the following guidelines when prescribing:
  - Follow national standards of care guidelines for treating conditions;
  - Prescribe drugs on WellCare's Preferred Drug List (PDL);
  - Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
  - Evaluate medication profiles for appropriateness and duplication of therapy.

- WellCare has pharmaceutical utilization management (UM) tools that are used to optimize the pharmacy program. These UM tools are described in detail in the Provider Manual including:
  - Preferred Drug List (PDL)
  - Drug Evaluation Review (DER) process
  - Mandatory Generic Policy
  - Step Therapy (ST)
  - Quantity Level Limit (QL)
  - Pharmacy Lock-In Program
  - Network Improvement Program (NIP)

Pharmacy (cont.)

Additional important information covered in the Provider Manual includes:

- ❑ Non-covered drugs and/or drug categories that are excluded from the Medicaid benefit;
- ❑ Over-the-Counter (OTC) items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by WellCare do not.
- ❑ Requesting additions and exceptions to the PDL through the Drug Evaluation Review (DER) process, including information on:
  - How to submit a DER
  - When a DER is required, including, but not limited to:
    - ❑ Most self-injectable and infusion medications
    - ❑ Drugs not listed on the PDL
    - ❑ Drugs listed on the PDL but still require a Prior Authorization
    - ❑ Brand name drugs when a generic exists
- ❑ Requesting an appeal of a DER request decision.

- ❑ For more information on WellCare's Pharmacy program, refer to the Provider Manual, the Quick Reference Guide, and the web for appropriate Forms, Documents and contact information.

Utilization Management (UM)

- WellCare's Utilization Management (UM) program includes review processes such as notifications, referrals, prior authorization, concurrent review and/or retrospective review.
- **Prior Authorization**

  - WellCare requires prior authorization for elective or non-emergency services as designated by WellCare.
  - Reasons for requiring authorization may include:
    - Review for medical necessity
    - Appropriateness of rendering provider
    - Appropriateness of setting
    - Case and Disease Management considerations
  - Decision timeframes are determined by either NCQA requirements, contractual requirements or a combination of both. See the Provider Manual for decision timeframes.
  - Prior authorizations may be requested via fax, phone or online at www.kentucky.wellcare.com. For more information on prior authorizations, and the information necessary to include in your request, refer to the Provider Manual and Quick Reference Guide.

Utilization Management (UM) (cont.)

WellCare

- **Concurrent Review**
  - Is initiated as soon as WellCare is notified of a member's admission to a hospital, LTAC, skilled nursing facility or acute rehabilitation facility.
  - Subsequent reviews are based on the severity of the individual case.
  - Providers are required to submit notification and clinical information on the next business day after the admission, as well as upon request from the WellCare Concurrent Review team.
    - Failure to submit necessary documentation may result in non-payment.
  - Discharge Planning begins upon admission and is designed to identify the member's post-hospital needs
    - The attending physician, hospital discharge planner, PCP, ancillary providers and/or community resources are required to coordinate care and post-discharge services to ensure the member receives the appropriate level of care.
  - Transitional Care Management identifies members in the hospital and/or recently discharged who are at risk for hospital readmission.
    - The member is contacted by a WellCare Care Manager to assist the member in reducing avoidable readmissions and/or offer Case/Disease Management.

Utilization Review (UM) (cont.)

WellCare

❑ Retrospective Review

- WellCare will review post-service requests for authorization of inpatient admissions or outpatient services.

- This review includes making coverage determinations for the appropriate level of services, quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization guidelines.

- A retrospective review can be initiated by WellCare or the provider.

❑ Transition of Care

- Members identified by the treating provider as having "special circumstances" such as a disability, a congenital condition, a life-threatening illness or is past the 24th week of pregnancy, are eligible for transition of care.

- During the first 90 days of enrollment, authorization is not required for those members with previously approved services by the state or another Managed Care plan.

- The member may continue to receive ongoing out-of-network treatment until the member is transitioned to an in-network provider.

- WellCare's obligation to pay expires:

  - ❑ Beyond the 90th day after the effective date of the termination from the previous plan
  - ❑ Beyond 9 months in the case of a covered person who at the time of the termination had been diagnosed with a terminal illness
  - ❑ Beyond the first 6 weeks following delivery of a newborn.

- In the event you are providing treatment to a member identified as having "special circumstances", please notify the UM department.

Utilization Management (UM) (cont.)

WellCare

- Refer to the Provider Manual for additional information including, but not limited to:
  - Criteria for UM decisions
  - Decision timeframes for service authorizations
  - Non-covered services and procedures
  - Limits to abortion, sterilization and hysterectomy coverage
  - Reconsideration for adverse determination (i.e., appeal)
  - WellCare Proposed Actions
  - Individuals with Special Health Care Needs (ISHCN)
  - Second Medical Opinion
  - Authorization request forms and Prenatal Notification Form.

- Forms are made available to assist you in gathering all pertinent information to enable WellCare to provide a timely response to your request.
- For more information on Utilization Management, Case Management and Disease Management, refer to the Provider Manual. For more information on authorizations and/or how to contact UM, CM and/or DM, refer to your Quick Reference Guide.

PCP Notification of Admissions

- Wellcare recognizes the importance of timely physician follow-up for members who are discharged from an acute care hospital to home. Timely and effective physician follow-up care enhances the quality of the member's health.

- Contracted PCPs will receive a "real-time" fax notification alerting them when an assigned member is hospitalized. The notification will contain sufficient information for the PCP to schedule timely and appropriate post-hospital follow up.

- Monthly summary reports by PCP can be generated upon request or at the discretion of Provider Relations to trend admission events by hospital and PCP.

- It is imperative providers frequently update contact information such as fax and phone numbers by contacting Customer Service or your Provider Relations representative.

Quality Improvement Program

- WellCare's Quality Improvement Program activities include, but are not limited to:
  - Monitoring clinical indicators or outcomes
  - Monitoring appropriateness of care
  - Quality studies
  - Healthcare Effectiveness Data and Information Set (HEDIS®) measures
  - Medical record audits
- Providers are contractually responsible for participating in quality improvement projects and medical record review activities.
- HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and providers to demonstrate the quality and consistency of care that is available to members
- WellCare is pleased to offer our Pay for Quality (P4Q) incentives for providers who meet certain quality indicators and outcomes. Additional information about this program is forthcoming.
- For more information on WellCare's Quality Improvement Program, refer to the Provider Manual.

Claim Submission Requirements

- Claims, paper and electronic, should include all necessary, completed, correct and compliant data including:
  - Current CPT and ICD-9 (or its successor) codes
  - Tax ID
  - NPI numbers
  - Provider and/or practice name(s) that match those on the W-9 initially submitted to WellCare
  - Correct taxonomy code consistent with Provider Demographic Information for the covered services being rendered
  - A preauthorization number, if applicable
- WellCare encourages providers to submit electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE). Both are less costly than paper and, in most instances, allows for quicker claims processing.
- All claims and encounter transactions are validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.
- For more information on Claims submission requirements and timeframes, refer to the Provider Manual, *Provider Resource Guide* and *Provider How-To Guide*.

Encounter Data Submission

- WellCare is required to provide encounter data to the Department for Medicaid Services that substantiates every service provided to every WellCare member.
- Financial sanctions can be imposed on WellCare by the Department for Medicaid Services if encounter data does not meet the Service Level Agreements for timeliness of submission, completeness or accuracy.
- Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to WellCare as follows:
  - Encounters submission will be weekly
  - Capitated entities will submit within ten (10) calendar days of service date
  - Non-capitated entities will submit within ten (10) calendar days of the paid date
    - *The above apply to both corrected claims (error correction encounters) and cap-priced encounters.*
- Encounters may be submitted electronically via:
  - WellCare's preferred clearinghouse, RelayHealth
  - WellCare's Secure FTP (SFTP) process
  - WellCare's Direct Data Entry (DDE)
- For more information on Encounter Data Submission requirements and submission methods, refer to the Provider Manual.

Appeals

- Providers have the right to file an appeal regarding provider payment or contractual issues.
- If the case is not appealed within the applicable timeframe, it will be denied for untimely filing.
- WellCare will review the case for medical necessity and conformity to WellCare guidelines. Cases lacking necessary documentation will be denied.
- When submitting an appeal:
  - Supply specific, pertinent documentation that supports the appeal
  - Include all medical records that apply to the service
  - Submit the appeal & accompanying documentation to the address on the Quick Reference Guide (QRG)
- Upon review of the appeal, WellCare will either reverse or affirm the original decision and notify the provider.

- For more information on provider appeals, including submission timeframes, how to submit and determination timeframes, refer to the Provider Manual and the Quick Reference Guide.

Grievances

- A provider may not file a grievance on behalf of the member without written consent from the member as the member's representative.
- Providers have the right to file a grievance no later than thirty (30) calendar days from the date the provider becomes aware of the issue generating the grievance.
- WellCare will provide written resolution to the provider within timeframes established. Extensions may be requested by WellCare and/or the provider.
- Providers may submit a grievance in writing
- For more information on member and provider grievances, refer to the Provider Manual and Quick Reference Guide.

For More Information...

WellCare

- Review the ***Provider Manual*** for more detailed information about provider requirements and how-to's including:

Provider and Member Administrative Guidelines	Claims	Credentialing
Utilization Management and Case & Disease Management	Quality Improvement	Appeals and Grievances
Delegated Entities	Compliance	Pharmacy Services

- Refer to the ***Provider Resource Guide*** and ***Provider How-To Guide*** as your one-stop-shop guides to the most common transactions with WellCare, including:
  - Registering for, and how to use, WellCare's provider portal such as member eligibility and co-pay information, authorization requests, claims status and inquiry, provider news and more;
  - How to file a claim via paper, electronically or via WellCare's Direct Data Entry (DDE);
  - How to file a grievance; and
  - How to file an appeal.
- Refer to the ***Quick Reference Guide*** for authorization requirements, addresses and phone numbers for key departments.
- Refer to the corporate ***Clinical Practice Guidelines*** and ***Clinical Coverage Guidelines*** to determine medical necessity, criteria for coverage of a procedure or technology, and best practice recommendations based on available clinical outcomes and scientific evidence.
- Contact your Provider Relations representative to schedule an in-service meeting.

SECTION IV.J PROVIDER SERVICES

51. Describe the MCO's proposed approach to promoting communication between providers and the MCO. Include a discussion of how the MCO 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 trainings, and enhance MCO-provider communication strategies.

Provide examples of how the MCO has successfully collaborated with providers to identify necessary changes and how these changes have been implemented. *(Page limit 2 pages)*

PARTNERSHIP AND TRANSPARENCY: THE KEYS TO PROMOTING COMMUNICATION

Across our affiliate plans, WellCare of Nebraska uses multiple strategies to communicate with our provider partners because we know that we can't achieve our goals to enhance the quality of life for our members, improve overall population health outcomes and reduce costs in the Medicaid program without an engaged provider network. These strategies range from the informal, such as forums with local leadership and providers to formal, such as the Provider Advisory Committee and monthly newsletters.

Communication with providers must be two-way to be effective. In implementing the Heritage Health program, we intend to establish engagement strategies to ensure that we not only are communicating important information to providers, but that we can solicit formal and informal feedback from providers to add to our many efforts for continuous programmatic and quality improvement.

In addition to meeting the requirements set out in Section IV.J of this RFP, other methods we will use to promote communication between WellCare of Nebraska and our Heritage Health providers includes:

- Quarterly roundtable discussions or forums with WellCare of Nebraska leadership
- Provider membership on oversight, quality and clinical committees including the Credentialing, Utilization Management, Clinical Advisory, Corporate Compliance, and Pharmacy and Therapeutics Committee
- Development of a formal Provider Advisory Committee to respond to provider concerns and develop provider trainings as well as get feedback on key initiatives or administrative changes
- Placement of provider services staff in our office in Lincoln as well as in welcome rooms in key locations across the state, including Omaha, Kearney, Scottsbluff and Norfolk to provide in-person support and a personal connection for individual and groups of providers to connect with us
- E-mail alerts as outlined by MLTC to ensure a broad and continuous education of our system and the greater health care landscape at large
- Monthly newsletters

ENGAGING THE PROVIDER ADVISORY COMMITTEE TO ENHANCE OUR PARTNERSHIP WITH PROVIDERS

In implementing the Heritage Health plan, we will use our Provider Advisory Committee to obtain input on a wide number of topics affecting our providers including administrative efficiencies, clinical policies, and operational issues. Examples of committee discussion items include health plan and provider experiences, coordination of care, quality initiatives, provider communication needs and educational opportunities, the integrated care model, operations, and access to care.

Our provider network liaison, who is identified as the provider services manager, will work directly with the Provider Advisory Committee to:

- Establish processes for responding to provider concerns

- Develop provider trainings in response to identified needs or program changes
- Enhance our provider communication strategies

It is important to note that we will ensure providers from different regions of the state are included in our Provider Advisory Council as well as other various opportunities to engage with us so that rural, frontier and urban provider concerns are equally heard and addressed. Varying provider types are reflected on the various committee structures so whether it's a primary care provider, a behavioral health specialist, a pharmacist, or a provider who mainly serves individuals with disabilities, they all have a voice in our processes.

Engaging providers on clinical policies, operational enhancements and administrative efficiencies

Through these many layers of engagement with providers, we will consistently seek opportunities to streamline administrative processes while focusing on clinical practices that best serve our members. To that end, in addition to the requirements outlined in the RFP we will engage providers through:

- Training including access to our secure provider portal
- Obtaining feedback on our provider portal to ensure an efficient and effective use of this powerful tool to track practice and member information
  - Our Florida plan, for example, used the opportunity of a redesign of the provider portal to seek feedback on the changes and make additional changes to reflect provider requests and input
- Active provider participation on our clinical and quality committees with provider input built into our continuous improvement practices
  - This includes the engagement of the Provider Advisory Committee as noted above

EXAMPLES OF COLLABORATING AND IMPLEMENTING CHANGE

WellCare's Georgia affiliate provides examples of changes as a result of provider collaboration. This plan has both a Provider Advisory Committee and a Behavioral Health Provider Committee.

As a result of provider engagement on these committees, our Georgia plan is in the process of instituting program changes, including:

- Changes in the behavioral health home program that is under development to include a significant increase in payments based on feedback that the proposed rate was not sufficient for providers to consider becoming behavioral health homes
- A partnership with the largest community mental health center on a new program to provide Omega 3 to patients with new onset psychosis due to the strong evidence this will improve outcomes and prolong the time to the next psychotic episode
- A coordinated activity with the two largest independent practice associations to enroll members in a computerized cognitive behavioral therapy program (COBALT) with modules for depression, anxiety, insomnia and substance abuse while they are in their provider's waiting room
- Modifications to the care plan engagement process to include the care manager accompanying high priority and complex care management members on their next appointment to review, emphasize, and develop care plan interventions if an integrated care team meeting is not possible or timely
- Expanded care plan delivery modes from the default of fax to include others such as hand delivery, email or through the provider portal

SECTION IV.J PROVIDER SERVICES

52. Provide a description of the MCO's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the MCO will acknowledge and resolve inquiries and grievances. Explain how the MCO will track provider complaints and how the MCO will use this type of information to improve provider services. Include a description of any type of internal reporting the MCO will perform, and how the MCO will use reporting information to influence the activities of the MCO's provider services representatives. *(Page limit 3 pages)*

WellCare's Approach to Handling Provider Complaints

WellCare maintains a comprehensive provider complaint program designed for ease of use as well as rapid and thorough responsiveness. Our goal is to resolve all provider complaints and inquiries accurately and timely to maintain our strong relationship with our providers. We have a strict and formal process, supported by robust tools and technology that ensures that every provider complaint is appropriately captured, logged, documented, tracked, resolved and reported on from beginning to end. In addition to resolving individual provider issues, we trend and analyze provider complaint data to identify potential systemic issues so that we can take action and prevent future sources of dissatisfaction.

Our established provider complaint process provides for the resolution of any disputes between WellCare and providers which is specific to providers. A provider complaint is defined as any verbal or written expression, originating from a provider and delivered to any WellCare employee, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by WellCare.

WellCare will develop a Nebraska specific written policy and procedure describing our provider complaint system, leveraging similar documents from other programs. These policies and procedures will be submitted to MLTC for review and approval at least 45 calendar days before the contract's start date. As part of our initial and ongoing training, provider service associates are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf.

A description of our provider complaint process is included in our provider handbook and on our website along with instructions on how to contact our provider services staff and the contact information for the staff person who receives and processes provider complaints. Our provider complaint policies and procedures will be distributed to our network providers at the time of contracting in a summary format with instructions on accessing the full policies and procedures on our website. This summary will include the ability of a provider to request a hard copy from WellCare at no charge to the provider. Out-of-network providers receive this information with the remittance advice.

We accept written provider complaints for a period of 30 calendar days, from the date of the issue or incident. We also give providers the opportunity to consolidate multiple complaints that involve similar issues, regardless of the number of individual patients or instances included in the bundled complaint. We understand there are times a provider needs to contact us with a general question, or obtain our assistance in resolving a problem. Our provider services teams are ready to assist our providers with these inquiries whether received over the phone, through email, in person or in writing. If our provider services team is unable to quickly assist the provider, they offer their assistance with helping the provider file a complaint.

Interactions, Correspondence and Timeframes to Acknowledge and Resolve

WellCare's goal is to resolve all provider complaints and inquiries accurately and timely. While the Heritage Health RFP does not appear to have mandated acknowledgement and timeliness standards governing provider complaints, our internal standard is to resolve all provider complaints within 45 calendar days of receipt and to provide written notice of the disposition. We have dedicated personnel that are authorized to receive and process provider complaints and all WellCare executives who have the

authority to review and resolve provider complaints are involved in the provider complaint process. Provider complaint data is reviewed by the Customer Service Quality Workgroup Committee, Utilization Management Committee (UMC) and the Quality Improvement Committee. Corrective actions are identified, as appropriate, and action plans are developed and monitored. Network providers serve on UMC and offer input through the review process.

Turn-Around Time
In third quarter 2015, WellCare resolved 100% of Medicaid provider complaints within 36 days.

We strive for the real-time resolution of all provider inquiries. In some cases, inquiries are resolved in real-time by a provider services associate who can appropriately clarify matters, provide necessary information, or rectify misinformation. When a provider services associate is not able to resolve an inquiry at the time of the call, we have designated departments with enhanced system capabilities that can take ownership of the call, a provider claims support team that handles high-level claims inquiries and a provider escalation team that handles highly escalated calls. If an inquiry cannot be fulfilled at the time of the call, we route the inquiry internally with all associated and available data to the responsible department. An outbound call is made to the provider within three business days from the date of the call acknowledging the issue was received and outlining an expected time frame for the issue to be resolved.

Each complaint is thoroughly investigated using applicable statutory, regulatory, contractual and provider subcontract provisions and all pertinent facts are collected from all parties in accordance with WellCare written policies and procedures. As part of the process, providers or their representatives are given the opportunity to present their case in person.

WellCare uses internal database applications to capture, track, and report the status and resolution of all provider complaints, including associated documentation, from receipt to resolution. This system captures and tracks all complaints, regardless of source or network status.

Tracking Provider Complaints and Improving Provider Services

As part of our global commitment to quality and service improvement, WellCare uses data from both provider complaints and inquiries to identify opportunities to improve our performance in functional areas such as grievance, medical management, administrative services, provider network development and handbook clarity. This allows us to address not only issues affecting individual provider satisfaction, but to also identify and address potential trends in the delivery system as a whole. As identified, prompt steps are taken to mitigate those issues that lead to provider complaints and inquiries.

Our goals for using this data are to:

- Use complaint and grievance data to drive our performance improvement process and improve operations or outcomes, or to make recommendations to the state about potential process improvements, such as a change to an administrative rule
- Improve the effectiveness and quality of our operational processes by identifying claim processing and billing errors and identifying opportunities for provider and internal claim processor education
- Increase member and provider satisfaction with the services provided by working across multiple departments (care management, provider services, configuration, etc.) to resolve member and provider concerns, creating a healthy relationship between member and provider
- Decrease the number of denial decisions that are reversed during the member and provider appeal processes by identifying repeat issues with correct billing, compliance with authorization requirements, and gaps in the provider network, then partnering with provider services and network development to educate providers and close network gaps

Examples of Service Improvements

Provider Contact Center: Our Georgia affiliate provider contact center team reviewed inquiry data from 2013 to determine the reason for increases in calls related to claims. This prompted the team to focus on first-call resolution in 2014 with the implementation of the provider claims support team, contact center technology enhancements, and additional claims training for provider services associates. With the new technology, improved claims training and the implementation of our provider claims support unit, we have seen direct correlations of reduced overall call volume.

Credentialing: In 2014 WellCare noted an increase of inquiries from providers checking on their credentialing status. When our provider complaint data began to reflect this same trend in credentialing issues, our provider services team began a thorough investigation of the entire credentialing process. The team reached out directly to some of the same providers that had filed the original inquiries and complaints and they discovered a pattern where a sample claim form was being requested and was rarely provided with the provider's credentialing packet. The provider services team determined this piece of information was not a critical element for credentialing. As a result, we removed the requirement and the credentialing team was able to quickly resolve many of the pending credentialing cases.

INTERNAL REPORTING AND ITS USE TO INFLUENCE ACTIVITIES OF PROVIDER SERVICES REPRESENTATIVES

All complaints and inquiries captured in our database applications are categorized to help easily identify trends and opportunities for improvement. WellCare produces a monthly internal report to track and trend provider complaints that include total number and type of provider complaints, date received and resolved, actions taken, and a summary of the complaint's disposition. Reports are reviewed by our provider services team to identify provider educational opportunities. As an example, if a specific complaint is received multiple times over several months, the internal report triggers our team to issue a widespread provider communication such as newsletter articles, bulletins, and field talking points to address concerns before additional complaints are received. Specific initiatives undertaken as a result of our provider feedback include:

- Outbound call unit established to proactively educate provider offices on balance billing issues and work with them to identify root cause and underlying issues. See Question 99 for additional detail.
- Clinical HEDIS practice advisors established to work with practices to improve HEDIS quality measures.
- Operations account representatives established with ability to adjust claims in real time and on-site at the provider's office.

SECTION IV.J PROVIDER SERVICES

53. Describe the MCO's plans and ability to support network providers' "meaningful use" of electronic health records and current/future Federal IT requirements. *(Page limit 1 page)*

MEANINGFUL USE SUPPORT

WellCare actively supports the use of Electronic Health Records by its providers, as well as the sharing of data through the statewide implementation of Nebraska Health Information Initiative (NeHII). The NeHII provides a secure electronic information infrastructure for sharing health information among health care organizations and offers health care providers the functionality to support meaningful use. We believe the Nebraska Health Information Initiative (NeHII) has a valuable role in transition of care by offering access to clinical records. NeHII currently holds or accesses records from a growing share of the hospitals and providers in Nebraska. WellCare was invited to provide input to the NeHII strategic planning meeting on October 2, 2105 where we encouraged NeHII to allow and encourage managed care organizations (MCOs) to provide information and have access to the data. This would facilitate member transitions between MCOs, providers and the patient centered medical home (PCMH). We were also the only known MCO to send participants to the annual Health Information Exchange (HIE) Users Group conference in late September, 2015 in Park City, Utah. We are preparing to work with any interested HIE to find mutually beneficial solutions to our common problems around medical record sharing.

FEDERAL IT REQUIREMENTS

WellCare continues to evaluate and follow federal and state guidance and requirements related to health care information technology. As meaningful use progresses from stage 1 and its focus on data capture and sharing, through stages 2 and 3 and the focus on advanced clinical processes and improved outcomes, WellCare intends to lead its internal and provider community to adopt these important goals. These federal goals align with WellCare's care model which emphasizes the right care in the right setting at the right time. WellCare regularly reviews applicable federal and state regulations and adjusts policies, procedures and training to reflect not only the letter of these regulations but to ensure the best possible care for our members.

PATIENT CENTERED MEDICAL HOME SUPPORT

WellCare has worked with providers in other states to assist them in the transition toward PCMH certification, in which EHR capabilities play an important role. This includes capitalizing on federal or state grants, or private funding to assist with seed funds to get them started. We will share data with providers across the system to help them determine the needs of their communities and determine their growth capacity and their ability to incrementally move towards a PCMH model. For example, our Georgia affiliate offers providers a PCMH pre-assessment form that includes an EHR capabilities tool.

We believe that allowing for the incremental growth of individual practices will develop a strong and comprehensive PCMH system over time, and that increasing the number of PCMH certified providers is a way to encourage provider's meaningful use of EHRs. The use of EHRs can assure that information from multiple sources is pulled together into a single system to support the comprehensive information needs of PCPs. To support providers in moving toward the WellCare PCMH recognition program, we will leverage our value-based purchasing program to provide incremental payment bonuses to non-PCMH practices with a minimum panel size who adopt EHRs.

WellCare uses other provider interaction opportunities to support meaningful use. We will direct providers to visit https://nehii.org/ to obtain more information on this program and guidance on how providers can make the NeHII connection. Our provider pre-visit checklist will include discussions about meaningful use and the adoption of NeHII.

SECTION IV.J PROVIDER SERVICES

54. Discuss how the MCO 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 pages)*

STRATEGIES TO ENGAGE AND EDUCATE PCPS IN PROVISION OF BEHAVIORAL HEALTH SERVICES

As a fully integrated health plan, our entire clinical system is designed to ensure that a whole-person, patient-centered strategy is fully executed and operational throughout all of our programs and lines of business nationally.

The June 2015 Nebraska Behavioral Health Workforce report indicated that 48 of Nebraska's 93 counties did not have a mental health provider in 2014 and 83 of Nebraska's counties were designated mental health shortage areas. This shortage of mental health providers in Nebraska requires an array of unique strategies that include supporting and enhancing the PCPs role in providing basic behavioral health services.

Our strategies include:

- Training PCPs to bolster their role in prescribing, medical management and the administration of behavioral health screenings
- Supporting prescribing PCPs with counseling for members and supporting co-location of licensed mental health professionals when possible
- Supporting the use of extender providers when appropriate and when supported by our data infrastructure to ensure quality outcomes
- Supporting and enhancing telehealth opportunities particularly to provide consultation to PCPs
- Identifying community-level leaders to bring together community stakeholders to find solutions unique to individual communities
- Ensuring services such as psychotherapy and counseling, which may not require the expertise level of a psychiatrist, are managed by behavioral health clinicians with better accessibility
- Contracting arrangements with PCPs that allow them to provide and bill for behavioral health services for which they are appropriately credentialed
- Partnerships with academic medical centers to facilitate the transfer of knowledge, resources and educational opportunities into rural and frontier communities to enhance the PCPs' ability to meet behavioral health needs

COORDINATION OF CO-EXISTING CONDITIONS

WellCare assists PCP and behavioral health providers in the coordination of care through:

- Ongoing support of provider practices with co-located services, particularly in practices like the state's Federally Qualified Health Centers (FQHCs) or 638 Tribal/Indian Health Service Clinics
- Flexibility in the use of forms, screenings and assessment tools to allow integration into EHRs
- Developing data sharing strategies either through portals, interconnectivity options or various reporting tools
- Supporting and facilitating grand rounding on shared cases with complexity
- Developing care plans for more complex members and identify care teams that include both
- Training and toolkits for both PCPs and behavioral health specialists to help them identify members where care coordination is needed and help them build strategies into their practice, such as internal rounds and consultation, to coordinate

- Relationship building with care managers, the primary care and the behavioral health care providers
- Connectivity to social safety net services, family caregiver support and other formal and informal supports
- Alternative payment structures for providers who have the infrastructure and a desire to take on more pieces of care coordination. In these structures, providers may be paid a per member per month (PMPM) to "own" management of their patients
- Supporting and monitoring the communication between the behavioral health provider and the PCP through medical record audits

An example of these coordination activities is our Behavioral Health Toolkit which supports the integration of behavioral health and primary care. The toolkit, which is posted on our website and featured in provider newsletters, helps PCPs manage their members with co-existing behavioral health conditions. Our provider services team receives training on the toolkit and educates PCPs on the integration of physical and behavioral health as part of initial and ongoing training. Plans are underway to develop PCP training modules on recovery and resiliency programs.

For PCPs who choose to operate as a PCMH, there are enhanced opportunities to coordinate behavioral and medical care delivery. As an example, through WellCare's monitoring of PCMH activities we are able to identify care gaps such as antidepressant medication initiation and maintenance to increase visibility to the PCP on their members' needs.

Finally, WellCare employs a web-based self-management tool for depression, anxiety, substance use disorders and insomnia. This tool, COBALT, allows for immediate access to self-management tools and in many instances after only one or two sessions, members are able to experience significant improvements in their symptoms. Having this capability can assist the PCP in having a ready referral to behavioral health assistance.

Our Georgia affiliate provides an example of screening for behavioral needs in primary care.

MEMBER STORY

Screening for Behavioral Health Needs in Primary Care: Integrated Teams Improve Member Outcomes

- A registered nurse who was part of a member's integrated care team was providing care coordination for the member's medical condition. Having been trained in the high rate of co-occurring depression for individuals with serious and chronic medical conditions, she administered a PHQ-9 and identified that the member screened positive for major depression. The nurse referred the member to a behavioral health care manager (BHCM) for a comprehensive assessment.
- A BHCM completed a face-to-face assessment and created a safety plan that incorporated the use of natural supports, including the member's sister. The BHCM coordinated care with a behavioral health specialist to secure an immediate appointment with a community-based provider to provide comprehensive, community-based, recovery-oriented services. While the assessment was being scheduled, the BHCM kept in contact with the member to ensure that the safety plan was followed.
- Because the care manager was trained to recognize the importance of screening in both primary care and behavioral health settings, the member received behavioral health supports and services in addition to treatment for a medical condition. Our integrated approach to addressing the continuum of member needs fostered this holistic approach to care.

SECTION IV.J PROVIDER SERVICES

55. Describe the approach the MCO will take to assess provider satisfaction, including tools the MCO plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes. *(Page limit 5 pages)*

APPROACH TO ASSESSING PROVIDER SATISFACTION

WellCare assesses provider satisfaction through a number of modes designed for frequent feedback. These include post-call surveys, website surveys and our quarterly Provider Advisory Committee. In addition we administer a more formal annual provider satisfaction survey to measure provider satisfaction with our health plans. This survey is designed to support NCQA standards for health plan accreditation, as well as ensure our provider satisfaction program remains compliant with key reporting requirements and any new requirements for our health plans. The survey helps identify opportunities for improvement by asking providers for feedback on a variety of topics, including:

- Overall satisfaction and loyalty
- Contact center/member services/provider services staff
- Provider relations
- Continuity/coordination of care
- Network
- Utilization and quality management
- Finance issues
- Pharmacy and drug benefits

Results are correlated to identify the items most important to overall provider satisfaction.

TOOLS, METHODOLOGY AND FREQUENCY OF ASSESSMENT

Our annual provider satisfaction survey is conducted by SPH Analytics (SPHA), a National Committee for Quality Assurance (NCQA) certified survey vendor.

SPHA provides guidance and resources, empowering expertise and innovation in survey design, data collection, analysis, and reporting. Their survey clients include more than 225 health plans for which they mailed more than five million surveys and conducted more than seven million calls in 2014. Information obtained from this survey allows WellCare to measure how well we are meeting our providers' expectations and needs. Based on the data collected, a provider satisfaction report is produced summarizing the results and identifying individual health plan strengths and opportunities.

WellCare provides SPHA with databases that consist of eligible providers for each of our plans. Databases are de-duplicated by SPHA against all other samples based on the national provider identification number. Up to eight surveys are pulled for each provider address among high volume PCPs and specialists. If necessary the sample is filled with other PCPs or specialists. SPHA uses a two-wave mail and internet, and a telephonic follow-up survey methodology to administer the provider satisfaction survey for each affiliate. Mail surveys are considered ineligible if returned for the following reasons: bad address with no forwarding information, provider is deceased, or if the provider no longer participates with the plan. In the case of our 2015 provider satisfaction survey, a total of 5,400 surveys were completed. WellCare's aggregate composite overall satisfaction for 2015 was 81 percent.

Peer Comparisons

All survey questions have specific response options designed for inclusion in our summary rate scoring.

These scores are computed as the proportion of favorable responses to the total number of valid responses for each question and are displayed as percentages. SPHA then compares our survey rate scores with their 2013 Medicaid/Medicare book of business or trend data to establish peer comparisons.

Our health plans in Florida, Georgia, New Jersey, and New York scored significantly higher than their peer health plans on the overall satisfaction and loyalty composite. Overall satisfaction correlations included:

- Helpfulness of provider services staff in obtaining specialist referrals
- Helpfulness of provider services staff in obtaining referrals to behavioral health services
- Timeliness to answer questions and/or resolve problems
- Timeliness to resolve complaints
- Process of obtaining member information (eligibility, benefit coverage, co-pay amounts)

Florida Provider Satisfaction

Our 2015 Florida provider satisfaction survey reported 87.3% of providers would recommend WellCare to other physicians' practices.

Survey Changes Based on Provider Input

Recognizing changes in the health care environment, SPHA recently evaluated our survey tool to confirm relevance of the survey topics, determine the preferred method of completing the survey, identify opportunities to increase response rates, and identify opportunities to improve the flow and ease of completing the survey. Focus groups were held with PCPs and specialists of varying practice sizes. A new provider satisfaction survey has been developed based on the outcome of that research. WellCare will implement this new tool for 2016. Benefits from upgrading to the new tool may include:

- More providers responding
- Shorter survey to prompt response
- Added value competitor-specific overall satisfaction questions
- More balanced response scale (based on provider feedback)
- Questions/topics approved by providers and office managers

The new survey will measure satisfaction with the following: all other plans (comparative rating), finance issues, utilization and quality management, network/coordination of care, pharmacy, health plan contact center service staff, provider services, and the health plan and competitors' plans.

RESPONSIBLE PARTIES

The provider communications team manages the survey process and is responsible for the administration and dissemination of results throughout WellCare.

Beginning in 2016, SPHA will provide performance improvement consulting services, which include identification and prioritization of improvement opportunities at the aggregate level, and documentation of best practices for improvement initiatives. SPHA will consult with our individual health plans to address improvement opportunities and activities. Meetings held with each health plan will address improvement opportunities and activities, including:

- Strategic and tactical plans
- Improvement activities
- Custom questions for the following year's provider satisfaction survey

Action plans will be developed and assigned to responsible parties with progress tracked through committee.

Using Survey Results to Implement Quality Improvements and Improve Outcomes

Provider satisfaction survey data is analyzed by our quality improvement team for strengths, opportunities, and areas to monitor. These results are presented to the Survey Core Planning Committee, which is typically chaired by provider services leadership with representatives from key operational areas.

Missouri Health Plan Example

Based on the 2014 provider satisfaction survey data, our Missouri affiliate, Missouri Care implemented a performance improvement project on the exchange of information between physical and behavioral health providers to promote coordination and continuity of care. The 2014 provider satisfaction report showed that overall Missouri Care PCPs and specialists were not receiving timely feedback and reports from behavioral health providers. Behavioral health providers also reported they did not send feedback and reports as often as they should, and it was not timely when sent. The lack of feedback and reports from behavioral health providers can potentially affect members' care. It is important for providers to be aware of all aspects of care given by behavioral health providers so medication interactions do not occur or conflicting plans of care are not followed.

In an effort to improve continuity and coordination of care between PCPs and behavioral health providers, the 2014 provider satisfaction survey results were presented to Missouri Care's service improvement committee (SIC). SIC is a cross-departmental committee, which advises and makes recommendations about service issues impacting members and providers. Through the committee's discussion, it was recognized that Missouri Care's provider services representatives should have talking points to promote continuity and coordination of care between behavioral health providers and PCPs.

Additionally, in 2014, Missouri Care identified an opportunity to improve relationships with behavioral health providers. The provider services department designated one provider services representative to work exclusively with the behavioral health provider network. This provider services representative visits high volume behavioral health provider offices and offers education, such as the importance of continuity and coordination of care between behavioral health care providers and PCPs. Goals were established based on the NCQA effect size table as shown in **Figure 10**.

Figure 10

Performance Improvement Metrics					
Provider Satisfaction Survey	**2014 Rate**	**Year Over Year**	**Goal**	**Goal Met Y/N**	**2015 Goal**
Q14. Do you receive feedback/ reports from Behavioral Health Clinicians regarding patients in your care?	53.7%	Baseline	Baseline	Baseline	59.7%
Q15. Timeliness of feedback/reports from behavioral health clinicians for patients in your care?	29.4%	Baseline	Baseline	Baseline	35.4%
Q16. Do you send feedback/reports to Medical Physicians regarding patients in your care?	66.3%	Baseline	Baseline	Baseline	71.3%
Q17. Timeliness of feedback/reports from Behavioral Health provider to Medical Physicians for patients in your care.	48.9%	Baseline	Baseline	Baseline	54.9%

Georgia Health Plan Example

Based on the 2014 provider satisfaction survey data, our Georgia affiliate is in the process of implementing a performance improvement project to increase provider satisfaction where it is most needed. They have partnered with a large regional provider group to implement multiple interventions with the goal of increasing their provider satisfaction rate by 10 percent. If the project is successful, they will scale the interventions to other regions as part of their ongoing commitment to maintain a high level of provider satisfaction.

Our Georgia market has made other improvements based on provider satisfaction survey results. This includes such actions as relaxing authorization requirements, improving the provider portal functionality, creating a provider appreciation program and implementation of the enhanced provider engagement program.

WellCare of Nebraska, Inc. Response to
State of Nebraska
Request for Proposal (RFP) for
Full-Risk, Capitated Medicaid Managed Care Program for
Physical Health, Behavioral Health, and Pharmacy Services
RFP Number 5151 Z1

January 5, 2016

ORIGINAL: Volume 2 of 2

WellCare Health Plans

SECTION IV.K SUBCONTRACTING REQUIREMENTS

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

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

(Page limit 1 page per subcontracting organization)

AN INTRODUCTION TO WELLCARE'S SUBCONTRACTORS PROPOSED TO SERVE NEBRASKA HERITAGE HEALTH MEMBERS AND PROVIDERS

To complement our internal capabilities, WellCare contracts with best-in-class service providers to offer the most advanced and effective services for our members and providers. The following is a brief list of key subcontractors we propose to use to serve Nebraska's Heritage Health members and providers. Details regarding each proposed subcontractor including its proposed role in the project, corporate background, and resources follow on the subsequent pages.

SUMMARY LIST OF PROPOSED KEY SUBCONTRACTORS	
Proposed Subcontractor Name	**Services to be Provided**
Administep.com LLC	Clearing House Services for Claims and Real-Time Transaction
Advanced Medical Reviews	Utilization Management Review & Determination
Alere Health Improvement Company	Maternity Risk Assessment & High-Risk Case Management
American Well	Telemedicine Services
Audiology Distribution LLC, d/b/a HearUSA	Hearing Management Services Vendor
CareNet Healthcare Services (Infomedia)	24 Hour Nurse Line
CDR Associates, LLC	Credit Balance – Recovery
Comprehensive Health Management, Inc.	Management Services
Concentrix	Claims Processing Services
Council for Affordable Quality Healthcare	Third Party Liablity
CSI Southeast Inc., d/b/a Interpretek	Sign Language Interpretation
CVS Caremark	Pharmacy Benefit Manager
CyraCom International, d/b/a Voiance Language Services	Telephonic Translation Services
Eliza Corporation	Interactive Voice Recognition – Member Risk Assessments
eviCore Healthcare LLC, f/k/a CareCore	Utilization Management Services
Financial Recovery Group	Claims Review and Overpayment
First Recovery Group, LLC	Third Party Liability – Subrogation
FOCUS Health, Inc.	Behavioral Health Utilization Management

Summary List of Proposed Key Subcontractors	
Proposed Subcontractor Name	**Services to be Provided**
HealthIntgrated	24/7 Behavioral Crisis Line
Health Management Systems, Inc.	Third Party Liability – Coordination of Benefits, Credit Balance, Data Mining
LifePlans, Inc.	Call Center Services (Live Member Health Assessments)
McKesson Health Solutions	Clearing House
Medical Transportation Management, Inc. (MTM)	Transportation Services
Multilingual Group, Inc.	Written Translation Services
ONEIL Digital Solution, LLC	Print Services
Premier Eye Care	Vision Management Services
RR Donnelley & Sons Company	Print Services
Symphony Performance Health, Inc., d/b/a SPH Analytics	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Syrtis Solutions, LTD	Third Party Liability – Verification of Benefits Eligibility
TPUSA, Inc. (Teleperformance)	Customer Service
Translation Station, Inc.	Interpreter Services - Providers' Offices
TransUnion Healthcare, Inc.	Third Party Liability

We acknowledge this list is preliminary, and we commit to submitting all proposed subcontracts for the provision of any services under this RFP for prior review and approval a minimum of 120 calendar days prior to the subcontract's planned implementation as required by MLTC. Additionally, prior to selecting a subcontractor, we will evaluate its ability to perform the activities to be delegated a minimum of 90 calendar days prior to the planned contract start date. We acknowledge that MLTC reserves the right to participate in these evaluations, and we must submit a copy of our findings to MLTC a minimum of 30 calendar days prior to the contract's start date. We further acknowledge MLTC has the right to review and approve or disapprove all subcontracts entered into for the provision of any services under this RFP, including but not limited to, our contract with our pharmacy benefits manager.

Subcontractor name: Administep.com LLC

Subcontractor's location: 4965 Preston Park Blvd., Suite 600 Plano, TX 75093-5150

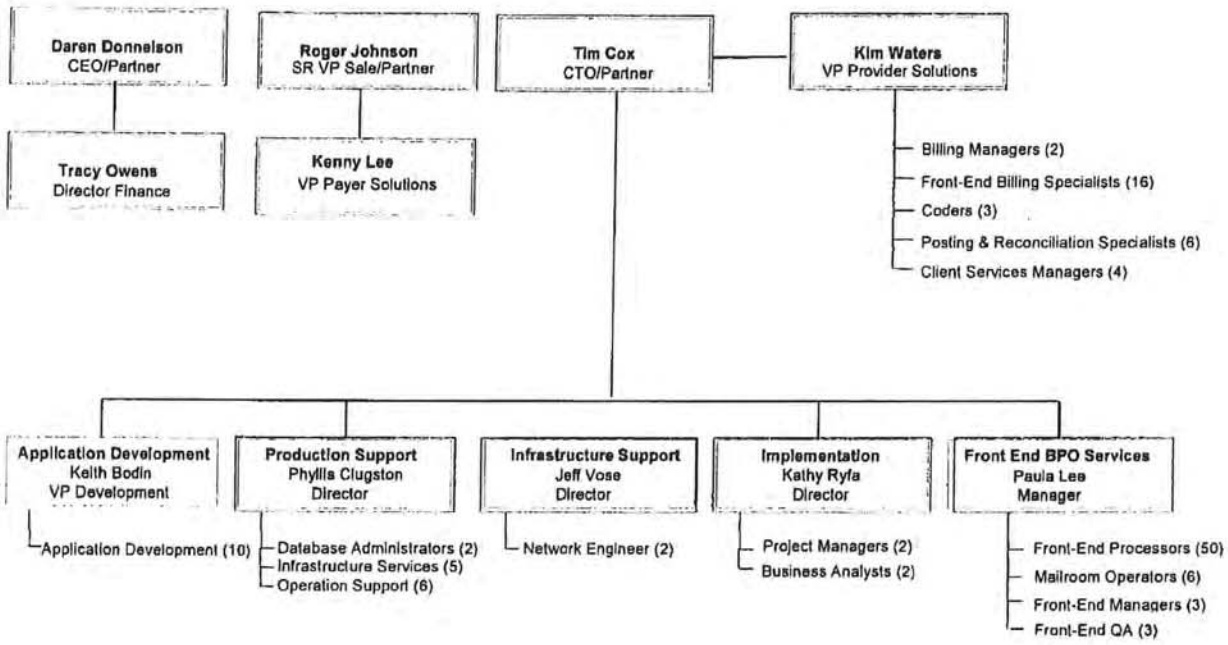
Description of role in project: Clearing House Services for Claims and Real-Time Transaction

Date company was formed, established or created: 1996

Ownership structure: Partnership; Limited Liability Company

Organizational chart:

ADMINISTEP ORGANIZATIONAL CHART



Total number of employees: 128

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Advanced Medical Reviews

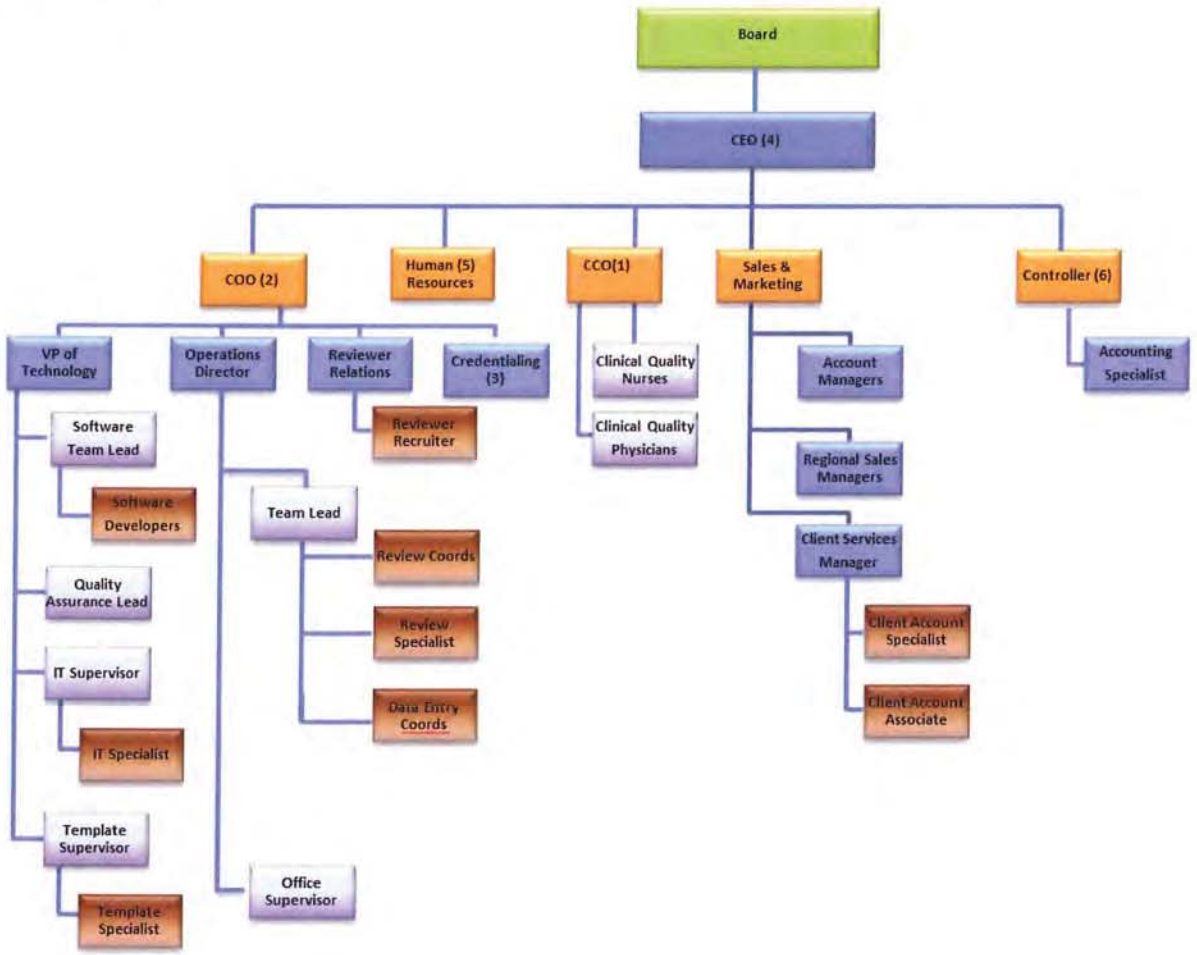
Subcontractor's location: 2950 31st Street Ste. 100, Santa Monica, CA 90405

Description of role in project: Utilization Management Review

Date company was formed, established or created: January 25, 2005

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 120

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Alere Health Improvement Company

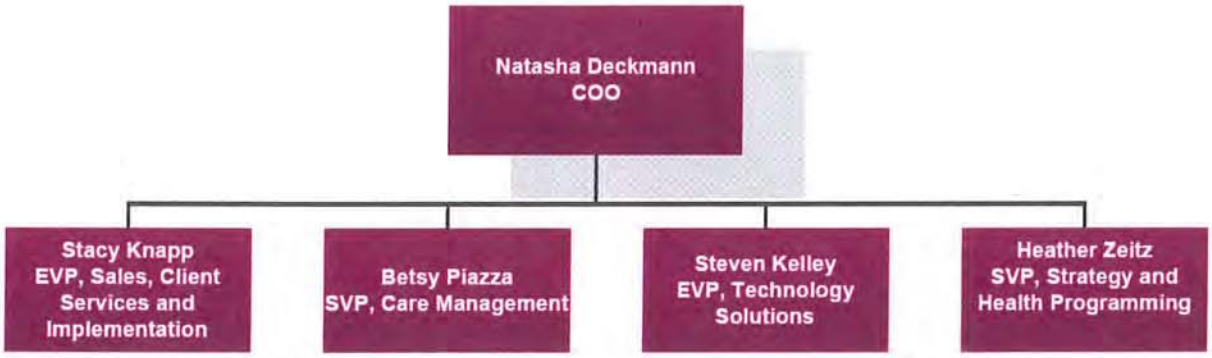
Subcontractor's location: 13625 Technology Drive, Eden Prairie, MN 55344

Description of role in project: Maternity Risk Assessment & High Risk Case Management

Date company was formed, established or created: October 13, 1993

Ownership structure: Corporation – publicly held

Organizational chart:



Total number of employees: Working on the CES business there are 7 employees. Working on the Credit Balance business there are 455 employees. Optum is part of UnitedHealth Group for which there are 170,000 employees.

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: American Well

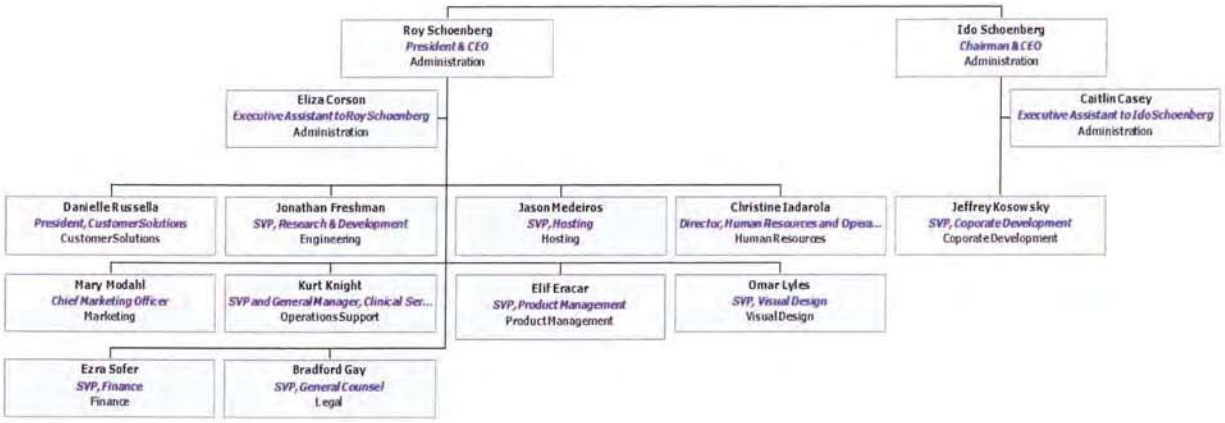
Subcontractor's location: 75 State Street, 26th, Boston, MA l2109

Description of role in project: Telemedicine

Date company was formed, established or created: 2006

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 222

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Audiology Distribution, LLC, d/b/a HearUSA

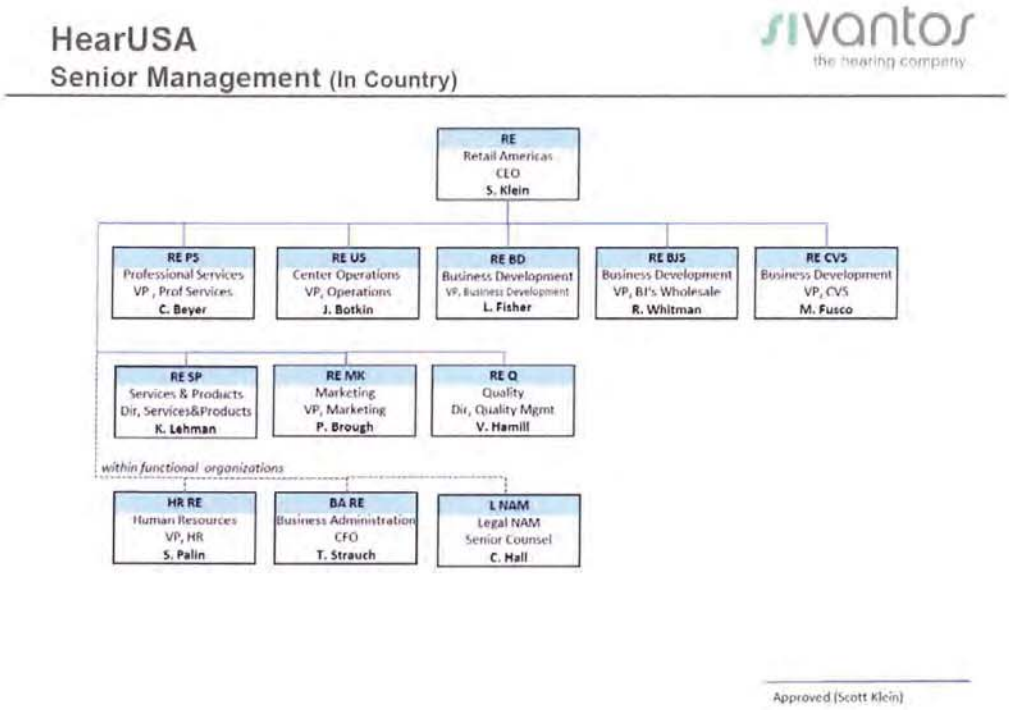
Subcontractor's location: 10455 Riverside Drive, Palm Beach Gardens, FL 33410

Description of role in project: Hearing vendor

Date company was formed, established or created: July 11, 2011

Ownership structure: Limited Liability Company

Organizational chart:



Total number of employees: Parent – 5,000, Subsidiary - 736

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: InfoMedia Group d/b/a Carenet Healthcare Service

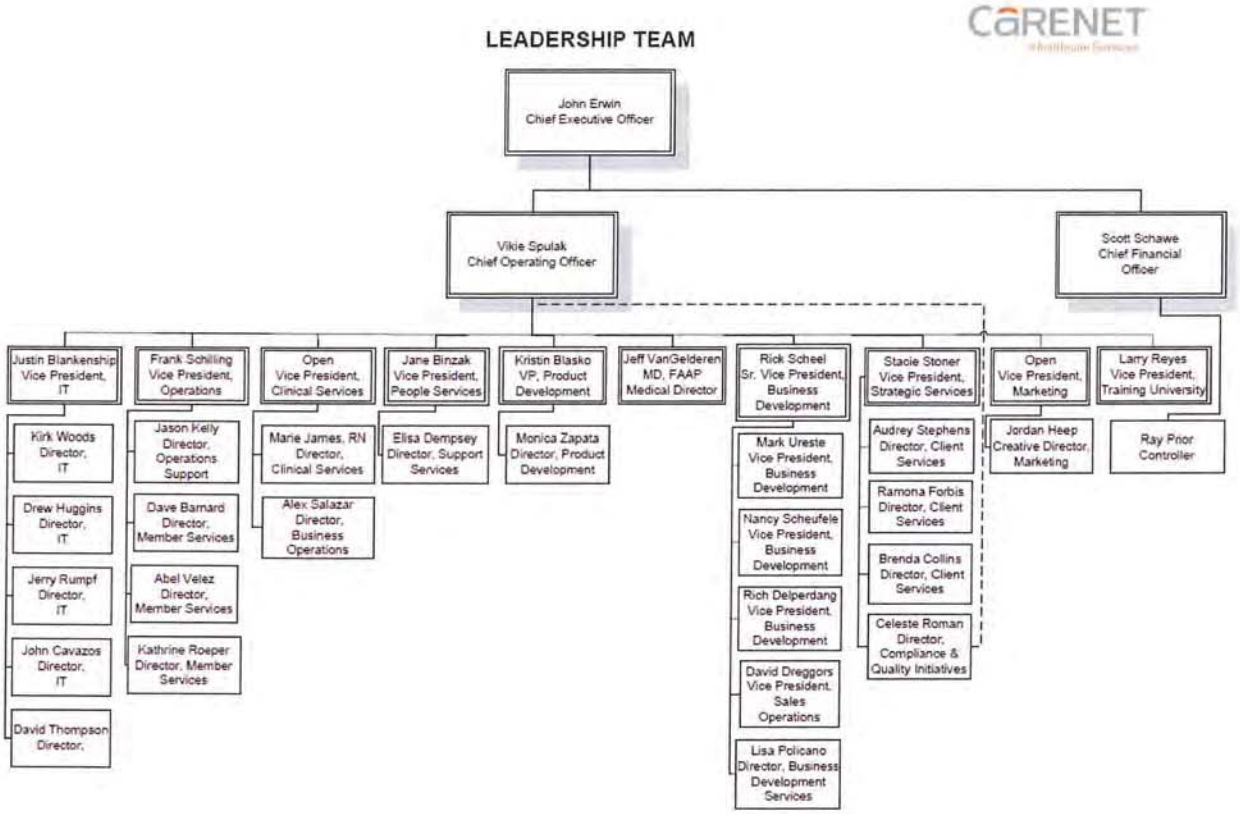
Subcontractor's location: 11845 IH 10 West Ste. 400, San Antonio, TX 78230

Description of role in project: Nurse Line

Date company was formed, established or created: 1988

Ownership structure: S-Corporation

Organizational chart:



Total number of employees: 800

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: CDR Associates, LLC

Subcontractor's location: 307 International Circle, Suite 300, Hunt Valley, MD 21030

Description of role in project: Credit Balance - Recovery

Date company was formed, established or created: June 1, 1991

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:

Note: CDR Associates, LLC is Owned by Xerox Commercial Services and reports to Connie Harvey, Corporate Vice President – Xerox Healthcare Services.

Total number of employees: Parent 35,000 Subsidiary - 910

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Comprehensive Health Management, Inc

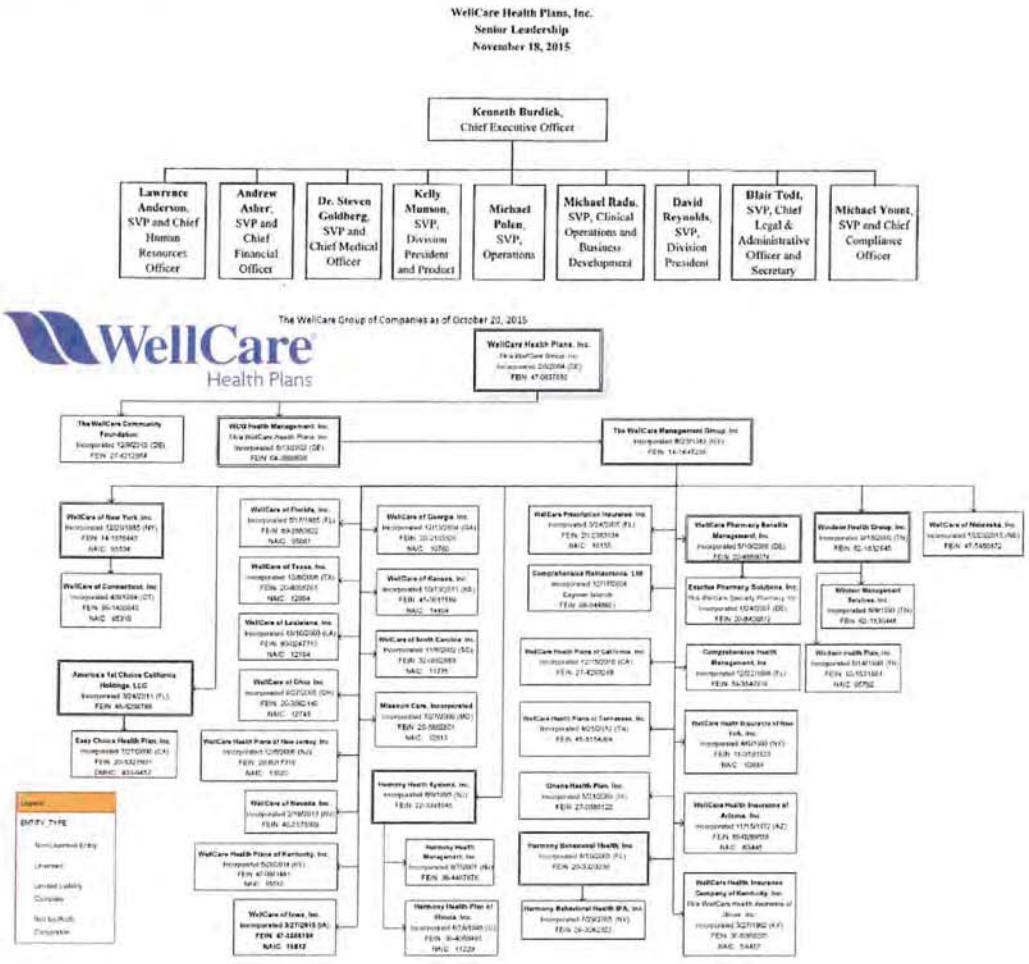
Subcontractor's location: 8735 Henderson Road, Tampa, FL 33634

Description of role in project: Management services

Date company was formed, established or created: December 22, 1998

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:



Total number of employees: 6,794

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Concentrix

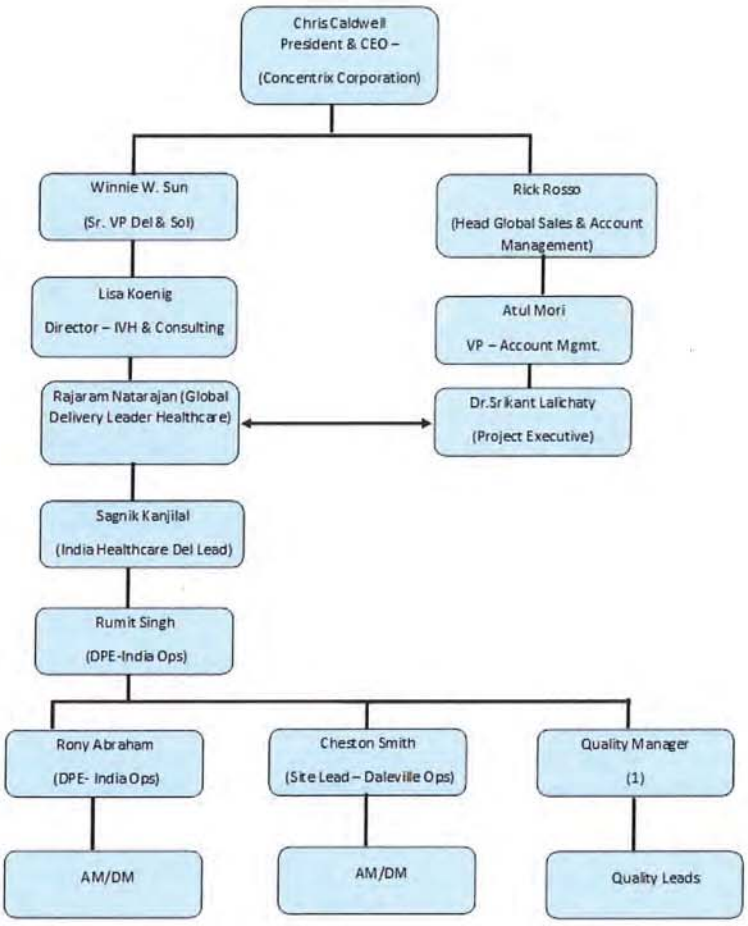
Subcontractor's location: Unit #101, 2nd Floor, Westend Mall, District Centre, Janakpuri, India

Description of role in project: Claims processing

Date company was formed, established or created: December 19, 1999

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:



Total number of employees: 54,000+

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Council for Affordable Quality Healthcare (CAQH)

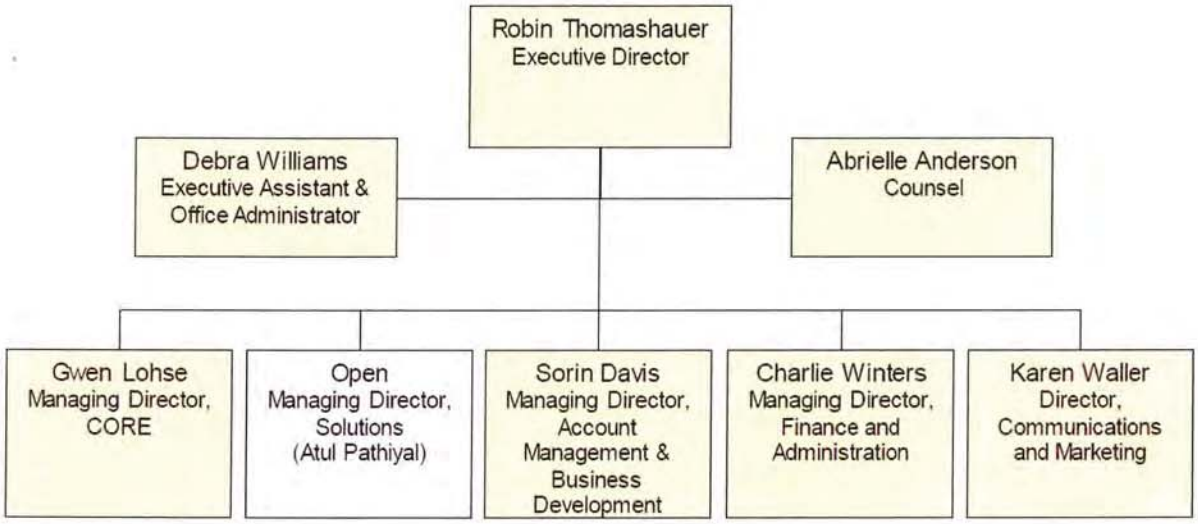
Subcontractor's location: 1900 K. Street NW, Washington, D.C., 20006

Description of role in project: Third Party Liability

Date company was formed, established or created: 1998

Ownership structure: Non-profit company

Organizational chart:



Total number of employees: 50+

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: CSI Southeast, Inc., d/b/a Interpretek

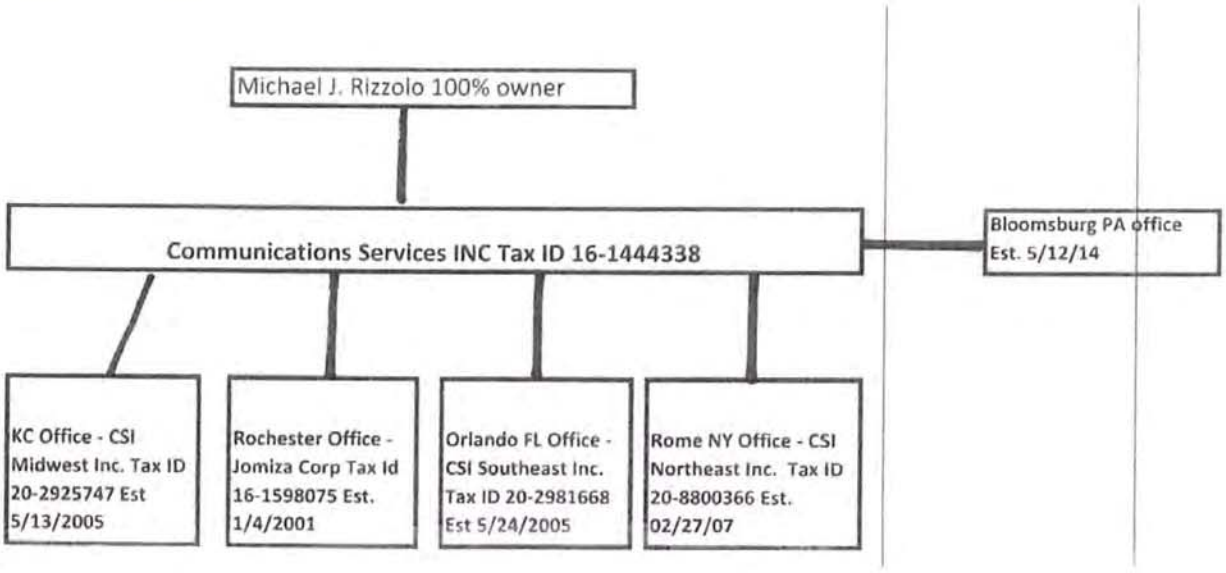
Subcontractor's location: 75 Highpower Road, Rochester, NY 14623

Description of role in project: Sign Language Interpretation

Date company was formed, established or created: August 18, 1993

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: Parent – 46, Subsidiary - 7

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: CVS Caremark

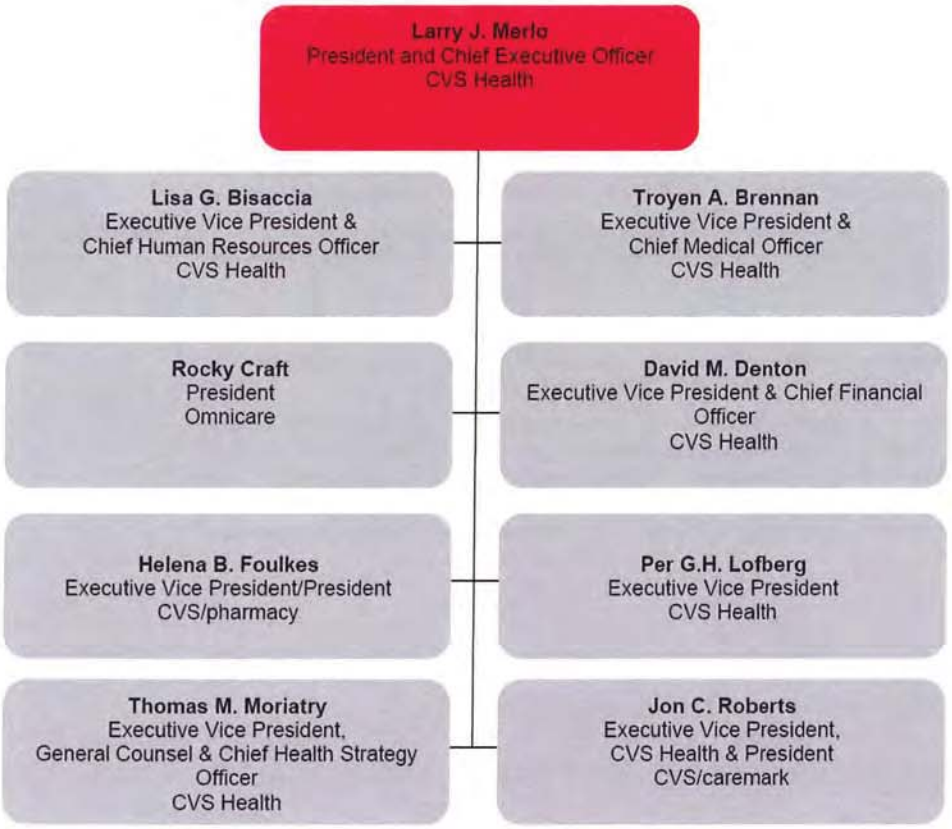
Subcontractor's location: One CVS Drive, Woonsocket, Rhode Island, 02895

Description of role in project: Pharmacy Benefit Manager

Date company was formed, established or created: 1969

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:



Total number of employees: Parent – 214,444, Subsidiary – 20,280

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: CyraCom International, d/b/a Voiance Language Services

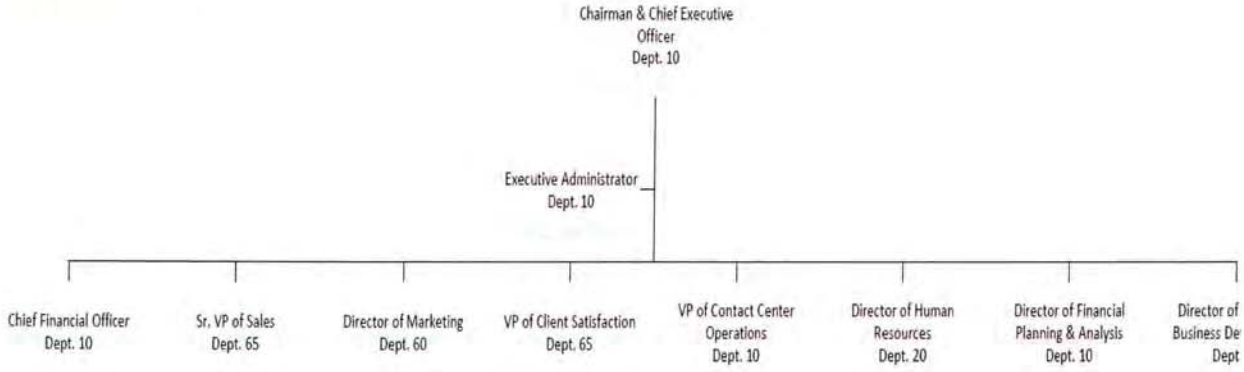
Subcontractor's location: 5780 North Swan Rd., Tucson, AZ 85718

Description of role in project: Language services

Date company was formed, established or created: May 19, 2008

Ownership structure: Limited liability company – not publicly held

Organizational chart:



Total number of employees: 2,032

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Eliza Corporation

Subcontractor's location: 75 Sylvan Street, Suite B-205, Danvers, MA 01923

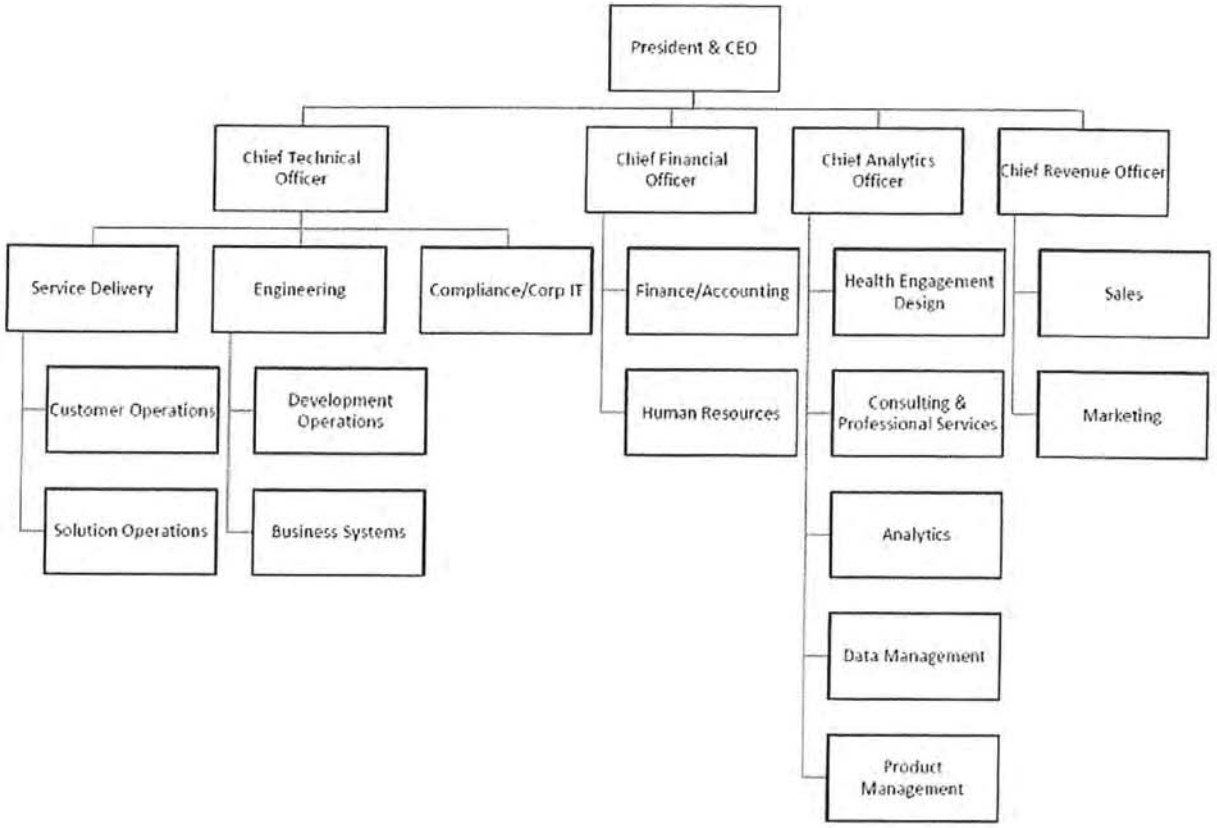
Description of role in project: Health risk assessment

Date company was formed, established or created: 1989

Ownership structure: Corporation – not publicly held

Organizational chart:

Eliza Corporation
Organizational Chart



Total number of employees: 200

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: eviCore Healthcare LLC, f/k/a CareCore National, LLC

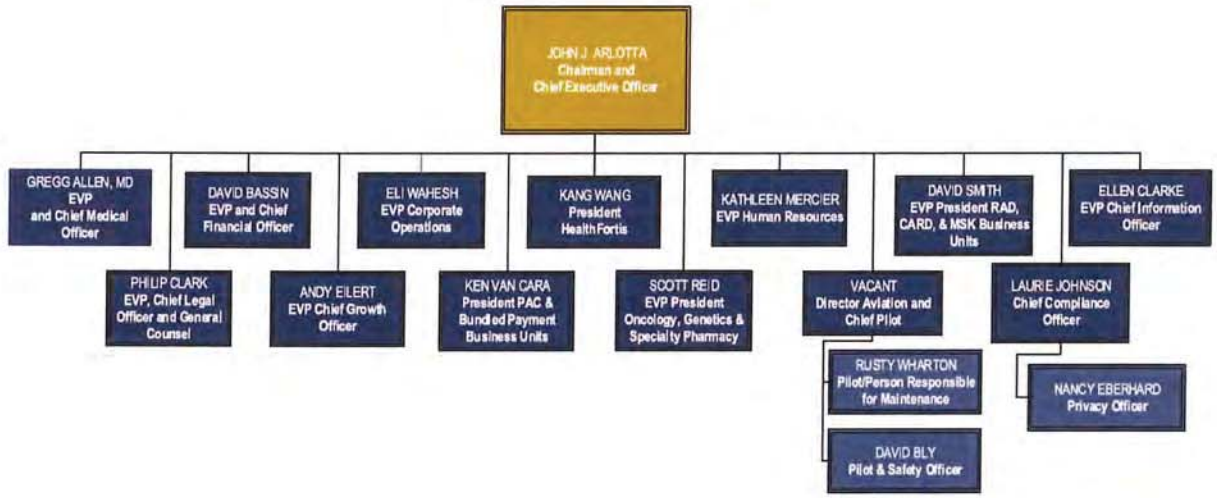
Subcontractor's location: 400 Buckwalter Place Blvd, Bluffton, SC 29910

Description of role in project: Specialized utilization management services

Date company was formed, established or created: January 12, 2001

Ownership structure: Limited liability company – not publicly held

Organizational chart:



Total number of employees: 3,157

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Financial Recovery Group

Subcontractor's location: 14707 S. Dixie Highway, Suite 401, Miami, FL 33176

Description of role in project: Claims review and recovery for overpayment

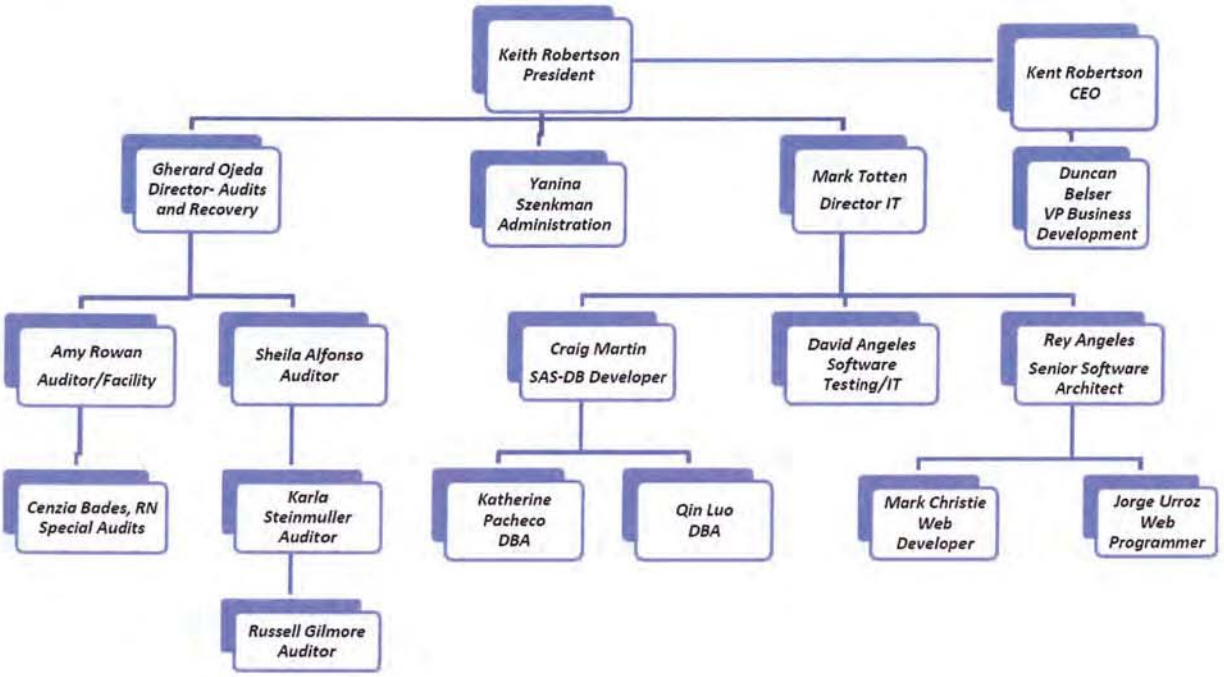
Date company was formed, established or created: Feruary 1999

Ownership structure: Corporation – not publicly held

Organizational chart:

FINANCIAL RECOVERY GROUP, INC.

ORGANIZATIONAL CHART



Total number of employees: 25

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: First Recovery Group, LLC

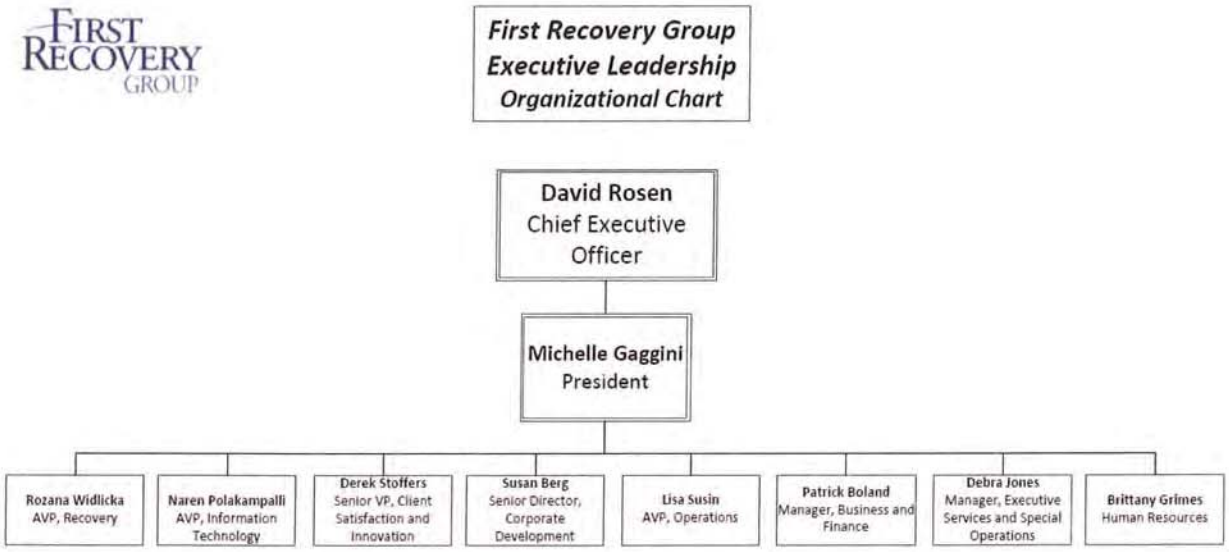
Subcontractor's location: 26899 Northwestern Hwy., Ste. 250, Southfield, ME 48033

Description of role in project: Third Party Liability - Subrogation

Date company was formed, established or created: July 13, 2000

Ownership structure: Limited Liability Company – not publicly heald

Organizational chart:



Total number of employees: 125

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: FOCUS Health, Inc.

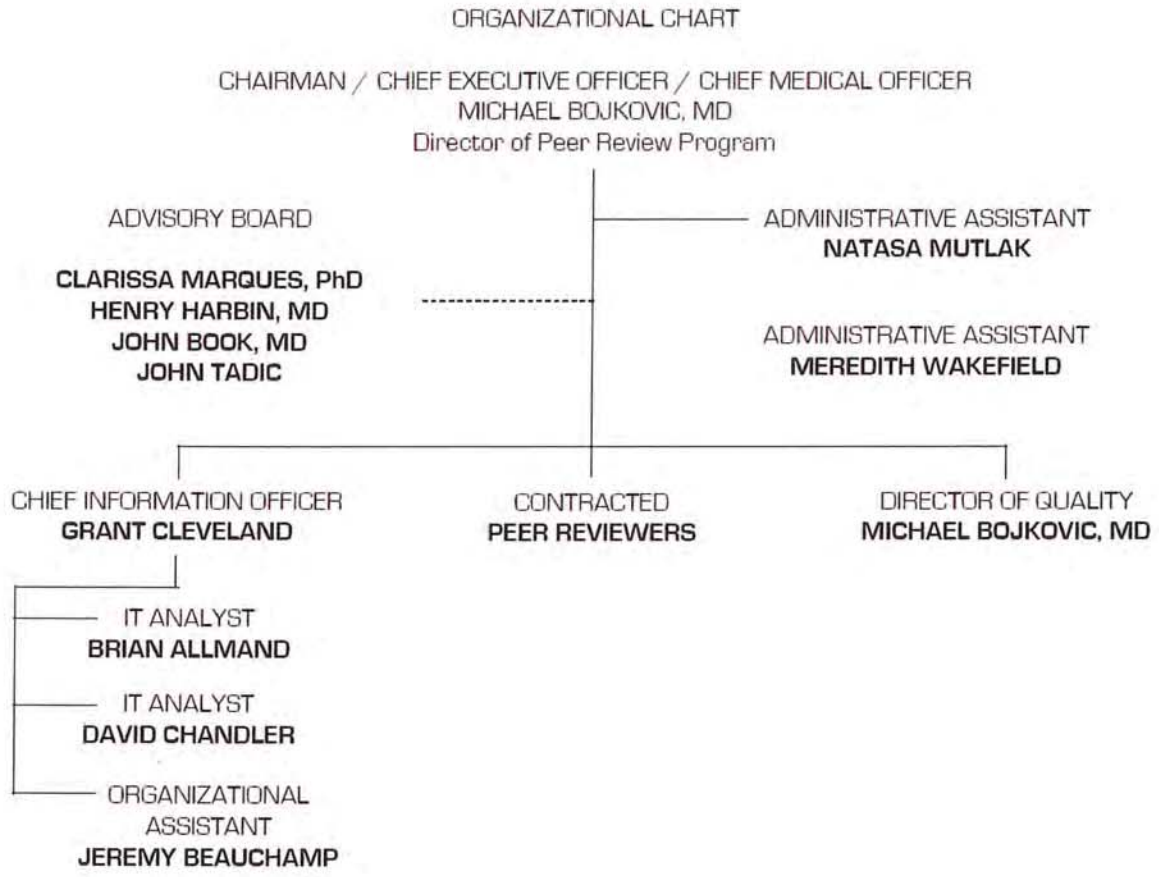
Subcontractor's location: 10801 Starkey Rd. #104-101, Seminole, FL 33777

Description of role in project: Behavioral health utilization management

Date company was formed, established or created: February 26, 2004

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 9

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: HealthIntegrated

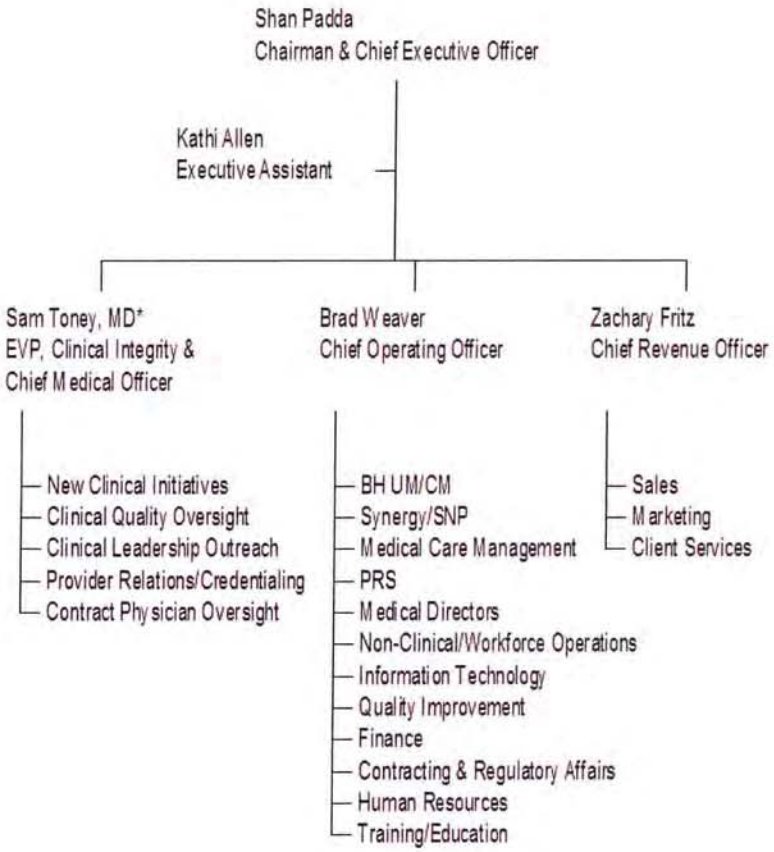
Subcontractor's location: 10008 N Dale Mabry Hwy., Tampa, FL 33618

Description of role in project: Behavioral crisis line

Date company was formed, established or created: January 30, 2003

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 452

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Health Management Systems, Inc.

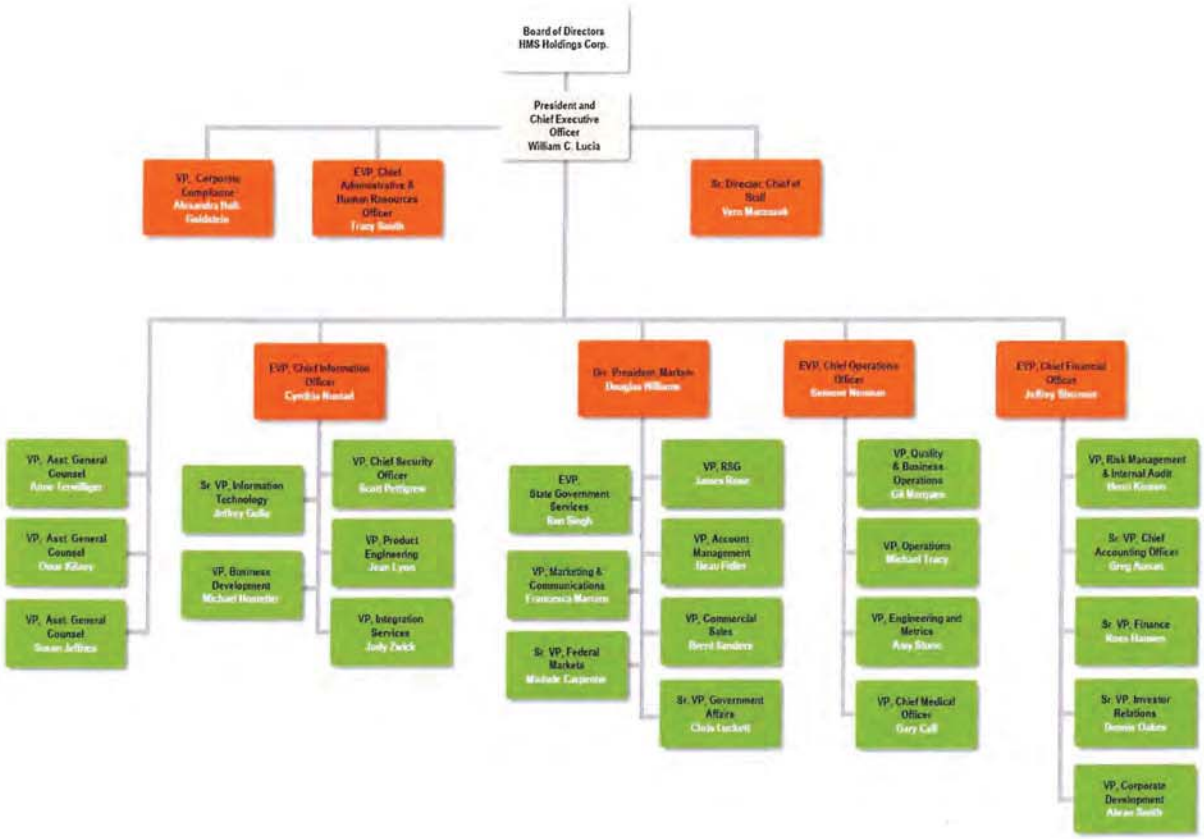
Subcontractor's location: 360 Park Ave. South, 17th Floor, New York, NY 10010

Description of role in project: Third Party Liability – Coordination of Benefits, Credit Balance, Data Mining

Date company was formed, established or created: October 4, 2002

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:



Total number of employees: 2,290

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: LifePlans, Inc.

Subcontractor's location: 51 Sawyer Road, Suite 340, Waltham, MA 02453

Description of role in project: Call Center Services – Conducts live caller health assessents for memebers

Date company was formed, established or created: 1986

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:

LifePlans

ORGANIZATIONAL CHART

Total number of employees: Parent - 43,500, Subsidiary – 166 + 4,000 contracted clinical network

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: McKesson Health Solutions

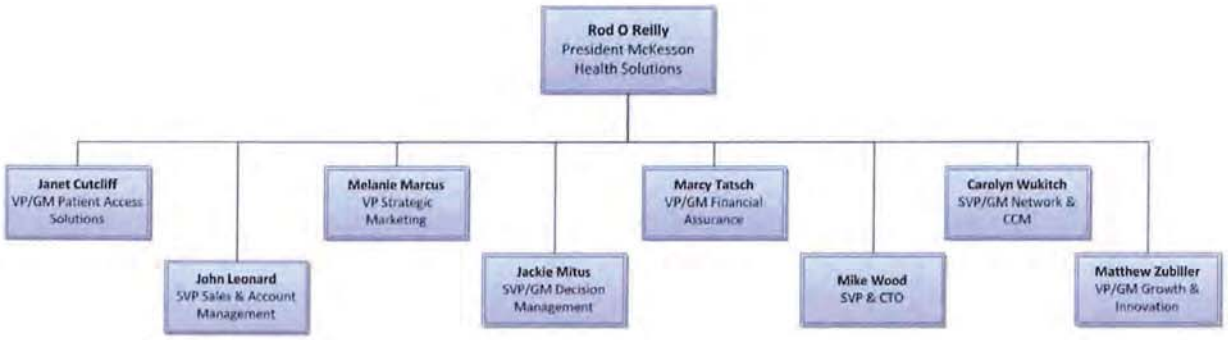
Subcontractor's location: 5995 Windward Parkway, Alpharetta, GA 30005

Description of role in project: Clearing house

Date company was formed, established or created: McKesson was incorporated in 1994

Ownership structure: Publicly traded company

Organizational chart:



Total number of employees: 1,510

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Medical Transportation Management, Inc. (MTM)

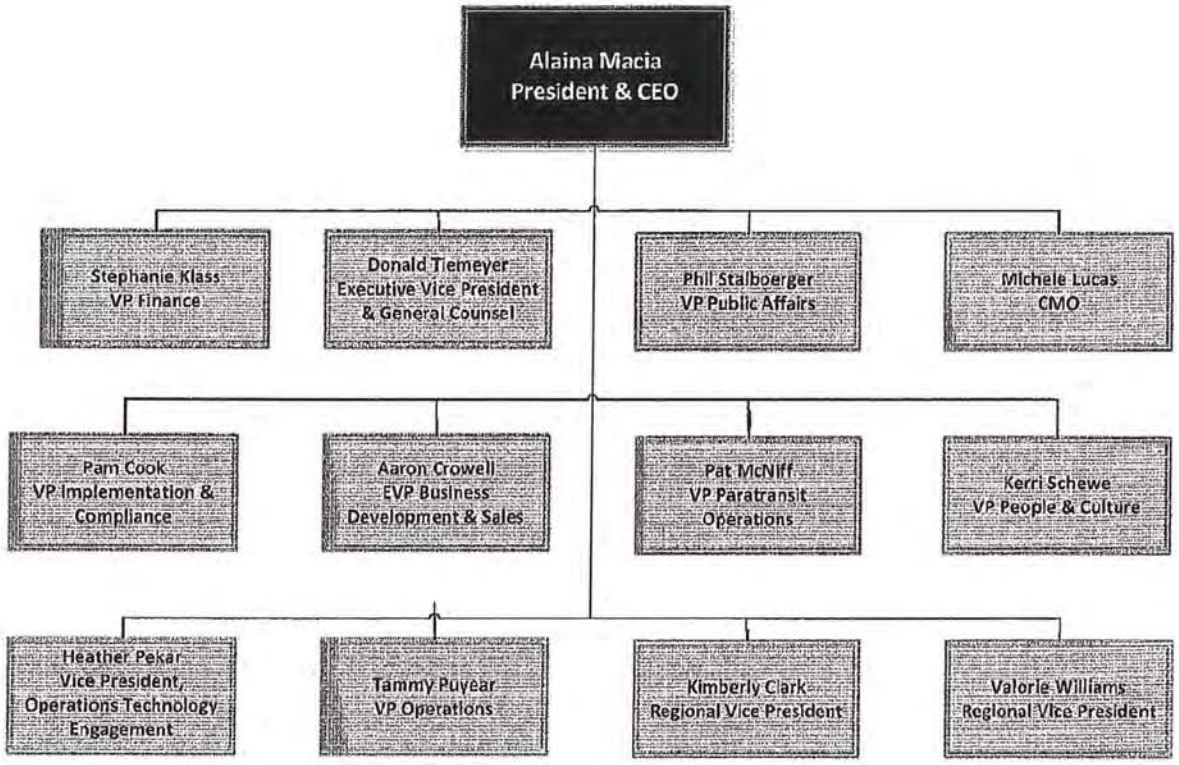
Subcontractor's location: 16 Hawk Ridge Dr., Lake Saint Louis, MO 63367

Description of role in project: Transportation

Date company was formed, established or created: June 27, 1995

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 948

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Multilingual Group, Inc.

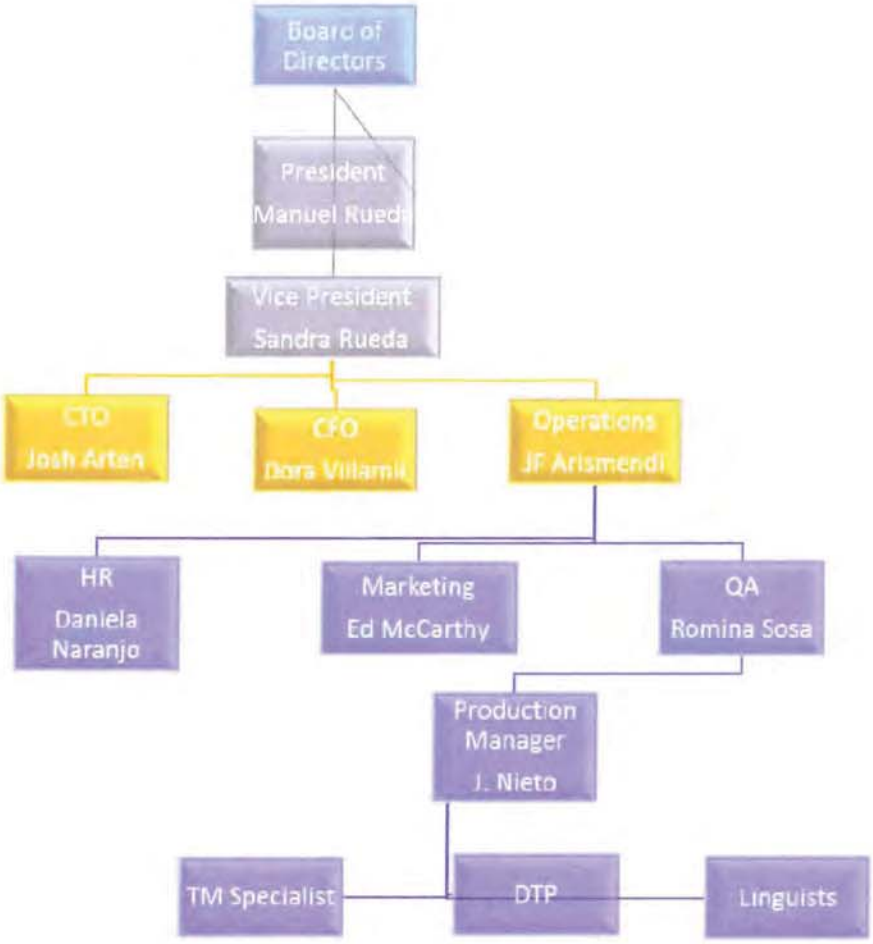
Subcontractor's location: 18-44 College Point, NY 11356

Description of role in project: Written Translation Services

Date company was formed, established or created: 2003

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 30

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: ONEIL Digital Solution, LLC

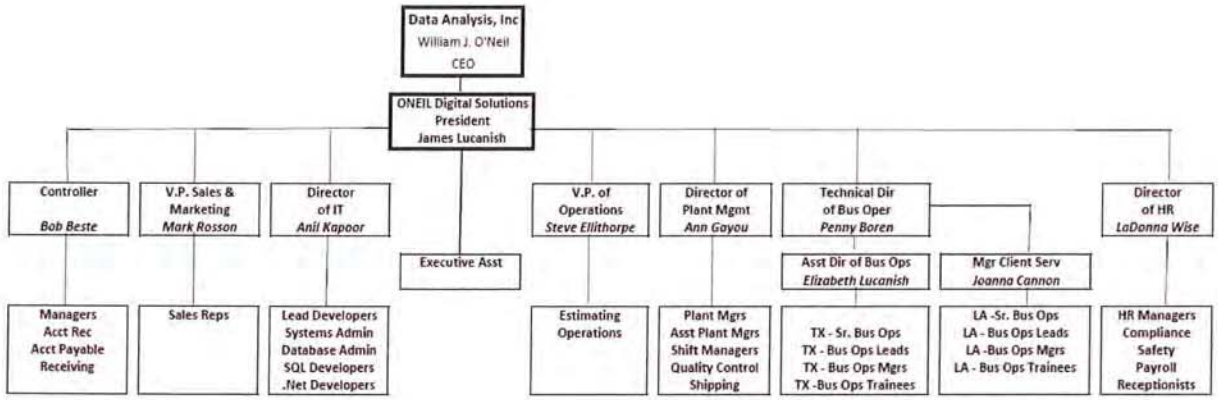
Subcontractor's location: 3100 E. Plano Parkway, Plano, TX 75024

Description of role in project: Production of welcome packets and member ID cards

Date company was formed, established or created: 2010

Ownership structure: Limited liability company – not publicly held

Organizational chart:



Total number of employees: 130

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Premier Eye Care

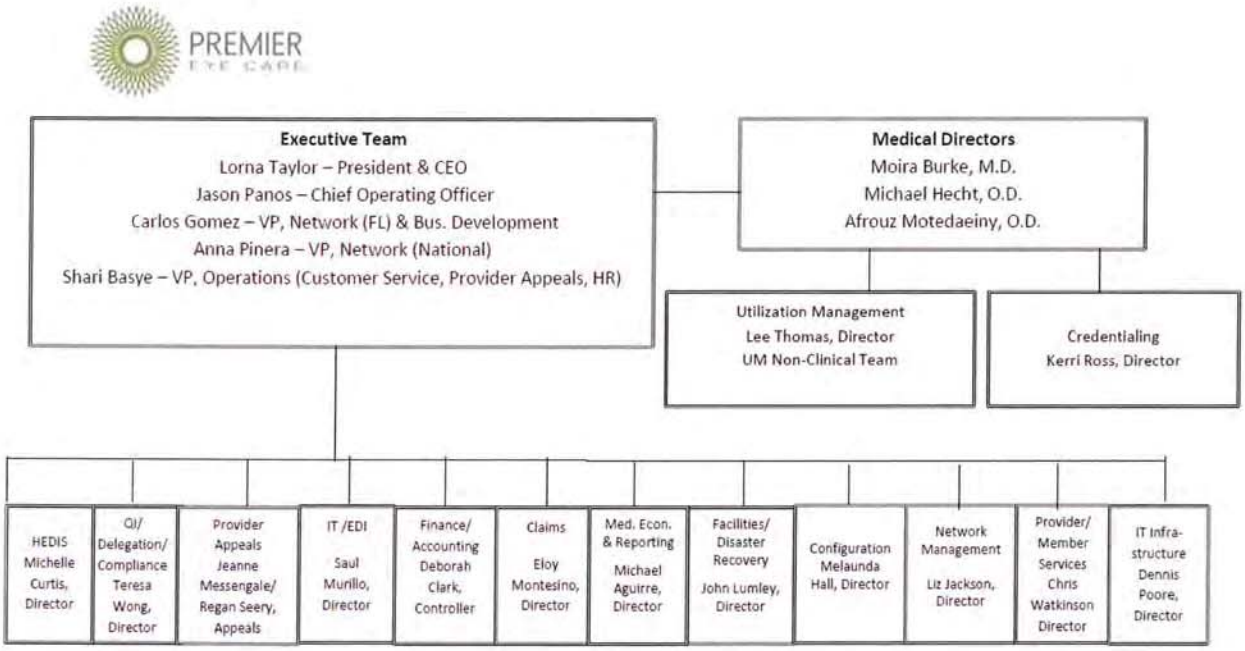
Subcontractor's location: 4205 West Atlantic Ave., Suite 01, Delray Beach, FL 33445

Description of role in project: Vision vendor

Date company was formed, established or created: December 1993

Ownership structure: Limited Liability Company –not publicly traded

Organizational chart:



Total number of employees: 92

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: RR Donnelley & Sons Company

Subcontractor's location: 35 West Wacker Drive, Chicago, IL 60601

Description of role in project: Print production of member and provider communications

Date company was formed, established or created: May 7, 1956

Ownership structure: Publicly traded company

Organizational chart:

Total number of employees: 68,000

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Symphony Performance Health, Inc., d/b/a SPH Analytics

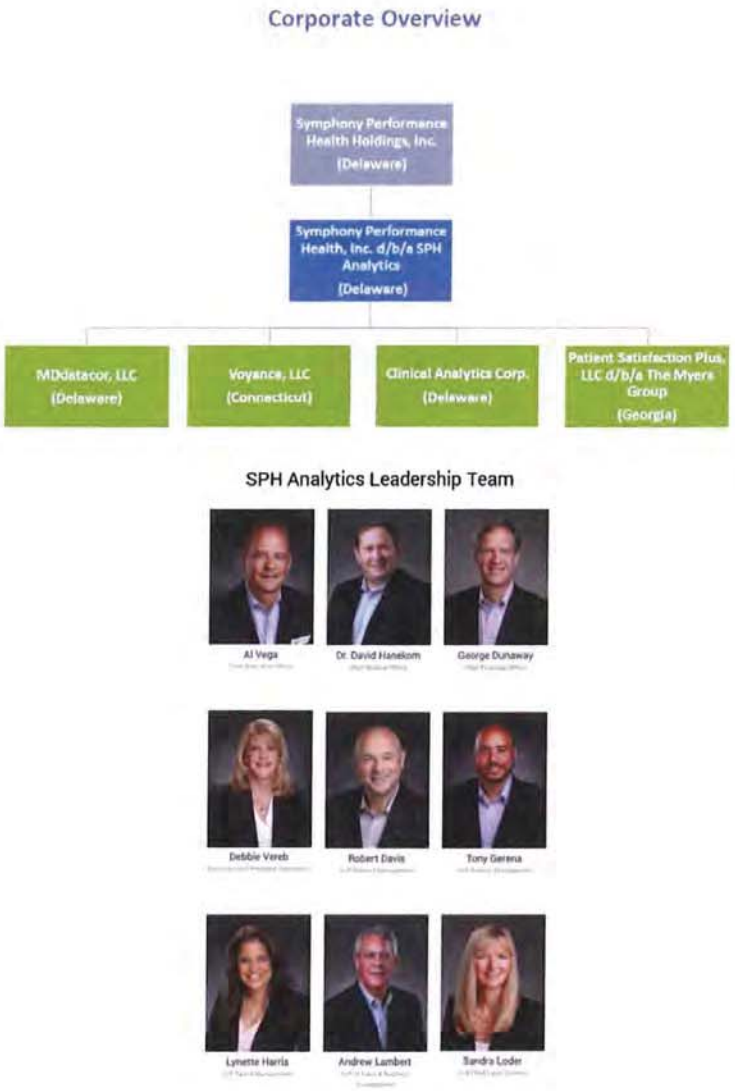
Subcontractor's location: 11545 Wills Road, Alpharetta, GA 30009

Description of role in project: HEDIS compliance audits and CAHPS

Date company was formed, established or created: January 17, 2014

Ownership structure: Corporation – not publicly held

Organizational chart:



Total number of employees: 350

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Syrtis Solutions, LTD

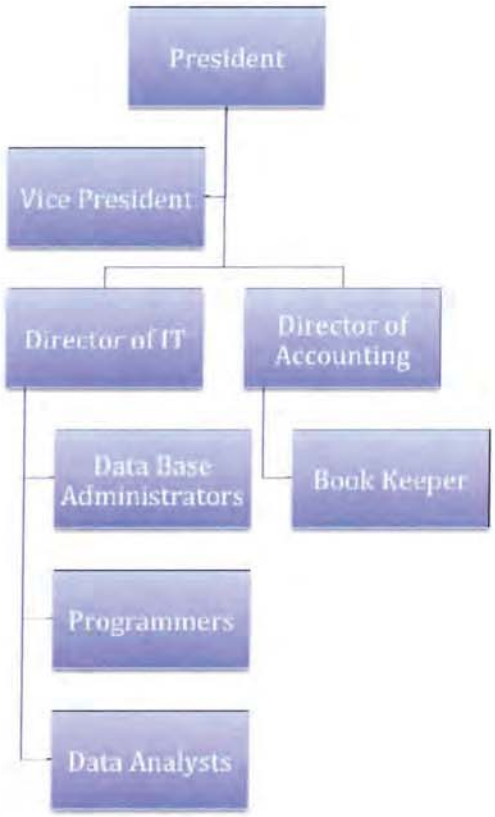
Subcontractor's location: 6380 Folsom Drive, Beaumont, TX 77706

Description of role in project: Third Party Liability – Verification of Benefit Eligibility

Date company was formed, established or created: July 10, 2009

Ownership structure: LTD Company

Organizational chart:



Total number of employees: 30

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: TPUSA, Inc. (Teleperformance)

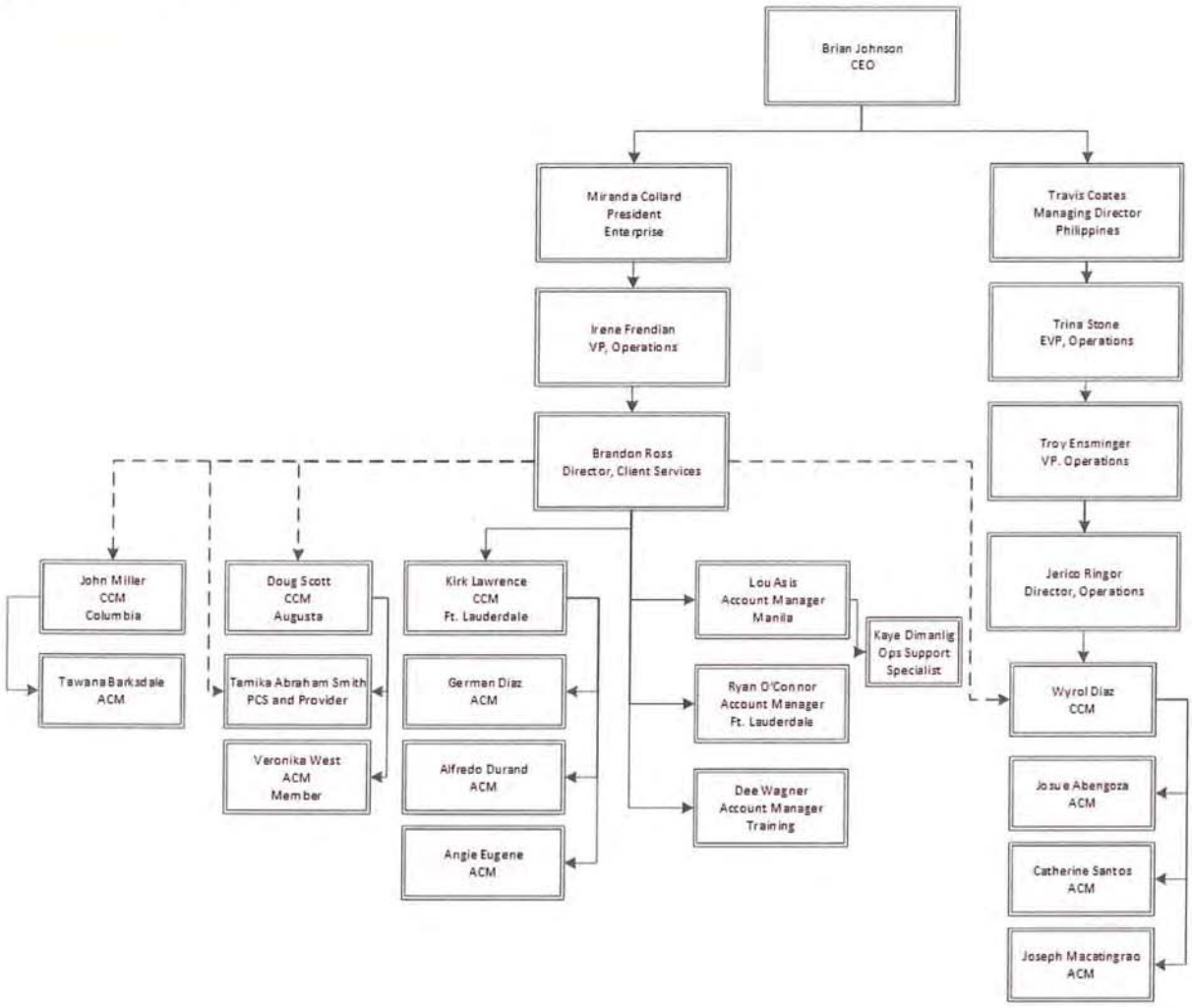
Subcontractor's location: 6510 S. Millrock Dr. Ste. 150, Holladay, UT 84124

Description of role in project: Customer Services

Date company was formed, established or created: 1993

Ownership structure: Publicly traded company

Organizational chart:



Total number of employees: Parent – 137,000, Subsidiary – 80,000

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: Translation Station, Inc.

Subcontractor's location: 3921 Flowers Road, Atlanta, GA 30360

Description of role in project: Interpreter services

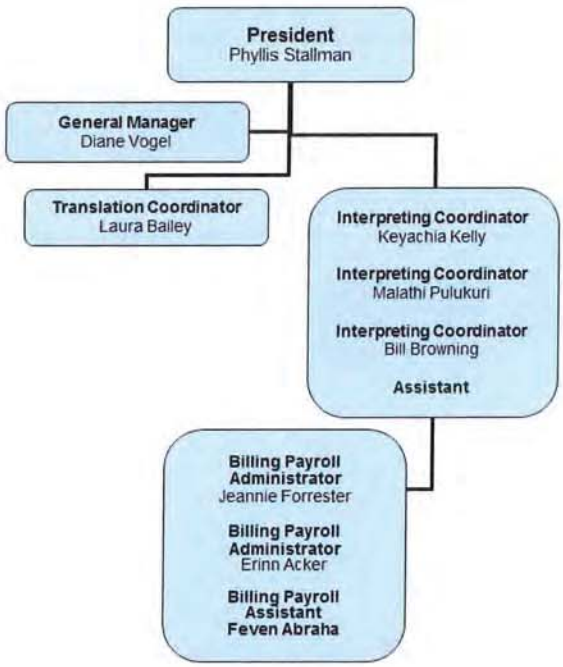
Date company was formed, established or created: 1998

Ownership structure: Corporation – not publicly held

Organizational chart:

TRANSLATION STATION, INC.
Language Solutions Made Simple

Translation Station, Inc.
Organization Chart
11/19/15



Total number of employees: 10

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

Subcontractor name: TransUnion Healthcare, Inc.

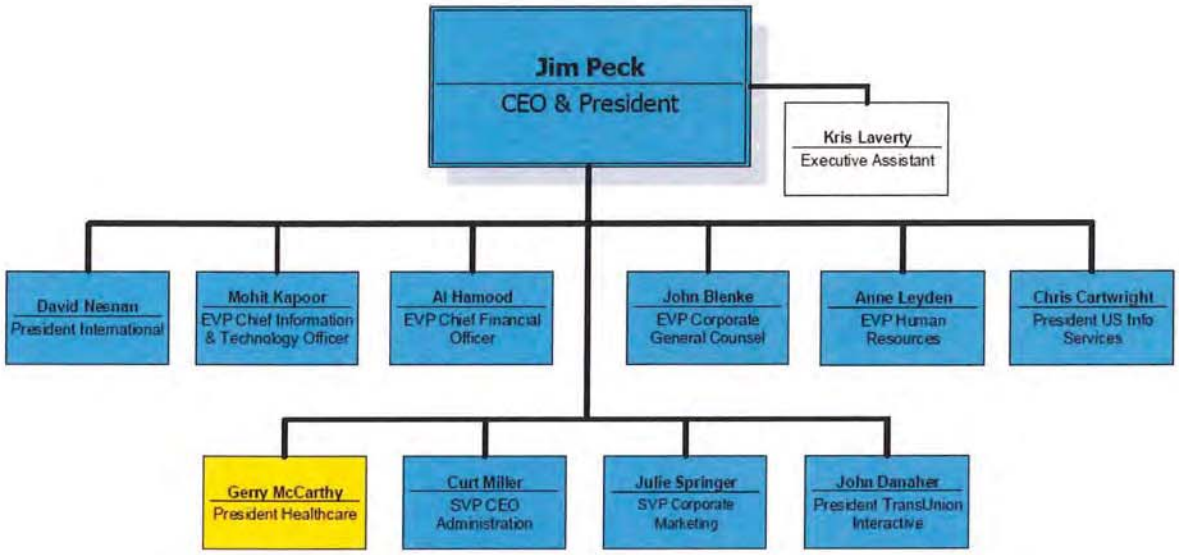
Subcontractor's location: 555 W. Adams St., Chicago, IL 60661

Description of role in project: Third Party Liability

Date company was formed, established or created: October 22, 2009

Ownership structure: Subsidiary of a publicly traded company

Organizational chart:



Total number of employees: Parent – 4,300, Subsidiary – 300

Does subcontractor currently provide services for WellCare: ☑ Yes ☐ No

SECTION IV.K SUBCONTRACTING REQUIREMENTS

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

- Ensure receipt of all required data including encounter data.
- Ensure that utilization of health care services is at an appropriate level.
- Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.
- Ensure adherence to required grievance policies and procedures.
- Ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC.

(Page limit 8 pages)

ENHANCING THE SERVICES WE PROVIDE THROUGH THE USE OF HIGH-QUALITY SUBCONTRACTORS

WellCare views subcontracting as a long-term business strategy where we selectively choose highly-qualified subcontractors to complement and enhance the services we provide to our members and providers. Our approach to determining what activities are sub-contracted is strategic, tailored to individual state needs and designed to enhance our operations while protecting members and providers. For example, WellCare's pharmacy operation is a hybrid model with a number of critical pharmacy functions performed in-house by WellCare personnel coupled with services performed by our contracted pharmacy benefits manager (PBM). Under our hybrid model, we retain in-house responsibility for coverage determinations, redeterminations, formulary development and management, Pharmacy and Therapeutics (P&T) Committee, quality, retrospective drug utilization reviews, rebates, and member and provider calls. Our PBM is responsible for pharmacy claims, pharmacy network development and management, audit, transition, after-hours provider calls and explanations of benefits. Similarly, ***with our decision to bring behavioral health management in house,*** we selectively use subcontractors to enhance the services we provide such as credentialing of behavioral health providers.

Our subcontractors are specialists in their respective fields and, because they work frequently with Medicare and Medicaid populations, they demonstrate broad and deep knowledge of the various populations and program requirements. ***Our ability to create a seamless experience in the delivery of benefits and services through our subcontractors is rooted in our Delegation Oversight Program, which is designed to achieve the MLTC's goals related to rigorous oversight of subcontractors.***

MONITORING AND EVALUATING SUBCONTRACTOR PERFORMANCE AND COMPLIANCE

As defined in our Delegation Oversight Program and the Nebraska Full-Risk, Capitated Medicaid Managed Care Program for Physical Health, Behavioral Health, and Pharmacy Services Scope of Work, a subcontractor is "any organization or person who provides a function or service for a MCO specifically related to securing or fulfilling the MCO's obligations under the terms of a contract." Our oversight program is based on our understanding that subcontractor relationships are an extension of us, and we are ultimately accountable for our subcontractors' performance related to all contract compliance requirements. This understanding has informed every element of our comprehensive subcontractor oversight program including our policies, organizational design, systems, and committee structure.

WellCare's Delegation Oversight System: Ensuring Quality Across 249 Subcontractors Nationally

Our industry-leading delegation oversight policies and procedures are operationalized through our

Delegation Oversight team, which is fully dedicated to subcontractor oversight across our network of 249 delegates covering 2.4 million Medicaid members nationally. This team, a unit of our Corporate Compliance department under the leadership of our Chief Compliance Officer, along with the functional business owners accountable for the contracts, are responsible for the overall onboarding of subcontractors as well as the ongoing oversight and monitoring of performance and compliance.

WellCare's Delegation Oversight team consists of subject matter experts who have experience in each of the functional areas they represent and oversee. Half of the associates are clinical professionals including registered nurses and licensed practical nurses. On an ongoing basis, these associates collaborate with functional business owners, including Encounters, Claims, Claims Audit, Utilization Management, and others regarding oversight requirements as well as pre-delegation audits, annual audits, monitoring, and completion of corrective action plans, as necessary. All delegation oversight staff members leverage the same systems and governance structure to support their day-to-day activities.

WellCare's Delegation Policy

In order to ensure quality services are provided to members and providers, it is our policy to thoroughly evaluate and certify work performed by subcontractors. Our formal evaluation occurs prior to initiating delegation with a prospective subcontractor and annually thereafter. Our monitoring of subcontractor performance and compliance is a formal, ongoing process that occurs throughout the year. Through our monitoring and oversight, activities we conduct include:

- Evaluating prospective subcontractors' abilities to perform activities to be delegated
- Ensuring subcontractors are financially stable
- Executing written contracts with subcontractors specifying the activities and reporting responsibilities delegated to the subcontractors and providing for the revocation of delegation or other sanctions if subcontractors' performance is inadequate
- Monitoring subcontractor performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards
- Identifying deficiencies or areas for improvement and taking corrective action

Ensuring Subcontractors are Able to Perform Activities at Least 90 Days Prior to Implementation

We acknowledge that we must submit all proposed subcontracts for the provision of any services to MLTC for prior review and approval. We commit to doing so a minimum of 90 calendar days prior to their planned implementation. Additionally, we understand that MLTC has the right to review and approve or disapprove all subcontracts entered into for the provision of any services under the scope of work, including but not limited to, our pharmacy benefits manager contract.

As noted in **Figure 1**, prior to delegating core functions (e.g., credentialing, utilization management, member services), WellCare performs due diligence, including a comprehensive assessment, to prospectively evaluate the subcontractor's ability to perform the activities to be delegated. This evaluation will occur a minimum of 90 calendar days prior to the planned contract start date. We understand that MLTC reserves the right to participate in these evaluations, and we commit to submitting a copy of our evaluation findings to MLTC a minimum of 30 calendar days prior to the contract's start date.

Figure 1

All WellCare pre-delegation audits are based on NCQA, and state and federal requirements. Our subcontractors are invited to log into our secure compliance system, Compliance 360 (C360), using a

unique password. There, they complete a comprehensive self-assessment and upload required supporting documentation including, but not limited to, policies, procedures, and sample reports. Once completed, the subcontractor submits the pre-assessment questionnaire and related documents to WellCare through C360 where it is routed, through embedded business rules, to a WellCare delegation auditor.

Upon receipt of the questionnaire and the supporting documentation, WellCare completes the following:

- A review of the services contract and related addenda to verify that:
  - Responsibilities are clearly delineated between WellCare and the entity
  - Appropriate statutory clauses exist
  - Appropriate periodic reporting exists to monitor the entity's activities
  - Appropriate remedial action rights exist for non-performance and/or non-compliance, including termination of services
- An extensive review of policy and procedures for the respective services to be delegated, as well as HIPAA, fraud, waste and abuse, business continuity, and compliance
- An analysis of the potential delegated entity's financial statements to verify solvency
- Verification that the entity has not been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7) or otherwise barred from participation in the Medicaid or Medicare programs.

Upon completion of the desk audit, the auditor then performs an onsite review of the subcontractor's facilities to verify capabilities to serve our members and providers. Here, we thoroughly review the subcontractor's staffing plans, interview the staff, and validate the entity's reporting capabilities.

Upon completion of the desk and onsite audits, the auditor determines if delegation is to be approved. If issues have been identified through the pre-delegation audit, they are documented and sent to the subcontractor, who is required to remediate all delegation issues within 20 days or otherwise forego delegation of services. If no issues are identified, or they are remediated timely, the auditor submits the delegate for approval to Delegation Oversight management. Delegation Oversight management reviews and approves delegation, if warranted, and reports the delegation to the Delegation Oversight Committee, Quality Improvement Committee, Corporate Compliance Committee and Regulatory Compliance Committee. The auditor also schedules a subsequent audit six months after the effective date of delegation of services. During this follow up audit we complete file reviews, where applicable, to evaluate the subcontractor's performance against our standards and regulatory requirements.

Ensuring Ongoing Subcontractor Performance and Compliance with Contract Standards

WellCare's success with subcontractor oversight begins with the pre-delegation process (as noted above) and continues with a collaborative performance management system as represented in **Figure 2**. Our Delegation Oversight team monitors and thoroughly evaluates the provision of core services provided by subcontractors and provides reasonable assurance that the delegated functions are in compliance with federal and state regulations, contractual obligations, accreditation standards and WellCare policies and procedures. Delegation Oversight's audit and monitoring activities include, but are not limited to, the following:

- Executing the Delegation Oversight audit and monitoring plan, including cross-functional collaboration to monitor the subcontractor's operational metrics
- Performing analysis and trending of data submitted by subcontractors to identify potential anomalies and areas of non-compliance
- Confirming on a monthly basis that subcontractors remain eligible for participation in the Medicaid and Medicare programs
- Ensuring that written agreements with each subcontractor are maintained and clearly specify the

entities' responsibilities, reporting requirements, and appropriate State and Federal clauses

- Issuing formal reports for each audit performed which identify opportunities to improve the subcontractor's controls and compliance with requirements
- Issuing formal corrective action plans based on audits and monitoring results
- Ensuring subcontractors implement adequate controls to remediate issues identified during audit and oversight activities
- Recommending sanctions up to and including the revocation of delegation and termination of services if the subcontractor continuously fails to comply with established standards
- Reporting to the Delegation Oversight Committee, Quality Improvement Committees, Corporate Compliance Committee, and Regulatory Compliance Committee on the compliance risks associated with delegated entity activities

Figure 2

Continuous Monitoring of Subcontractor Performance to Ensure Contract Compliance

WellCare formally monitors subcontractor performance on an ongoing basis. WellCare monitors and trends transactional data then analyzes results of monitoring and auditing activities and solicits appropriate corrective action plans when deficiencies are identified. WellCare has a suite of reporting tools that allow transparency into monitoring and auditing activities performed, status of audits and monitoring plans, metrics on outstanding corrective action plans, and trending of subcontractor performance through scorecards. This layered approach to oversight allows WellCare to ensure subcontractors are performing in accordance with contract provisions.

WellCare conducts monthly Joint Operating Committee (JOC) meetings with national subcontractors to monitor performance with key performance indicators, communicate critical information and provide performance feedback – WellCare to the subcontractor and subcontractor to WellCare. JOC meetings are specific to the functions delegated and include participants from the subcontractor, National Ancillary, Member Services, Encounters, Delegation Oversight, Clinical Services, Claims, and Compliance.

Ensuring Receipt of Required Data Including Encounter Data

WellCare understands the significance of providing complete and accurate encounter data to MLTC for purposes such as federal reporting, rate setting, risk adjustment, service verification, quality improvement, utilization patterns, access to care determinations, and research studies. We will comply with the required format and timelines provided by MLTC and will ensure encounter data includes claims paid or denied by our subcontractors for services delivered to members through the specified reporting period. We acknowledge our responsibility to ensure that our subcontractors comply with MLTC requirements within the specified timeframes. WellCare's dedicated Encounter team is responsible for ensuring complete and timely encounter data from our subcontractors. Upon contract award, WellCare will document specific requirements for the Nebraska submissions in our Encounter Data Submission Companion Guide. We will then meet individually with each of the subcontractors to review the Companion Guide and

submission rules. We will then initiate testing by creating test files and an extensive set of test scenarios. This test cycle will be key to having accurate data submissions post-implementation. Beyond the encounter data submission set up and testing, our Encounters team will use a variety of methods to ensure ongoing receipt of accurate and complete data including

- **Contracts:** WellCare's contracts contain specific language detailing the requirements for encounter data submissions. Subcontractors are required to submit encounters in a HIPAA compliant 837 transaction format. Encounter transactions must meet standard rules set by the Strategic National Implementation Process (SNIP) edits as well as comply with all state and federal validation guidelines. Any encounter that does not meet these requirements is reviewed, adjusted, and resubmitted by the subcontractor within 30 days of the initial notification of rejection. WellCare provides HIPAA standard response files as well as custom reports which must be reviewed by the subcontractors. Subcontractors must submit 100 percent (as tracked by CDJ/835) of all encounters with an overall acceptance rate of no less than 95 percent or as superseded by specific state requirements within 90 days from date of service. Compliance with this requirement is monitored monthly and measured as an aggregate of 12 months via Encounter Scorecard Monthly Reports.

  For the two most recent reporting periods, our subcontractors had an average overall encounter acceptance rate of 95 percent.

- **Encounter Scorecard Monthly Reports:** As a data-driven organization, our Encounter Scorecard Monthly Reports are a key element of our oversight program. The scorecards track submission frequency and volume, compliance and accuracy of provider submissions by subcontractor. The scorecard includes the number of encounters submitted by subcontractor by month, the number passing front-end quality edits, and the number accepted by the Medicaid agency. Data is reported for each provider and subcontractor and is used by management, the national ancillary team and the local affiliate leadership to manage subcontractor activity.
- **Subcontractor Education:** To complement the Encounter Scorecard Monthly Reports, WellCare conducts targeted education sessions with our subcontractors. The goal of our education sessions is to ensure quality submissions by teaching subcontractors how to correct errors with their encounter data.
- **Contract Enforcement:** WellCare uses the contract to enforce encounter data timeliness, completeness and accuracy. We develop corrective action plans (CAPs) and track adherence to these CAPs until the subcontractor comes into compliance. WellCare also applies financial penalties if encounter data acceptance levels are not met. Subcontractors who continue to perform poorly with encounter data submission are subject to further disciplinary action including revocation of functions if necessary.
- **Pharmacy Encounter Data:** We use our PBM to develop the encounter data submission and to reconcile the response files. WellCare and our PBM have a shared responsibility to correct any errors and to ensure all service levels are met, as outlined in our contract. Currently, our PBM supports D.0, Post Adjudication 4.2, and Post Adjudication 4.4. They will, however, make modifications in accordance with MLTC's specifications. WellCare will use a Reporting Package developed by our PBM to ensure accurate, timely, and complete submissions. Additionally, we will have a dedicated subject matters expert within WellCare who will specialize in pharmacy data and who will support the Nebraska pharmacy submissions ongoing.

Ensuring the Appropriate Utilization of Health Care Services

In addition to annual delegation audits, subcontractors are required to submit all utilization determinations to WellCare so we can systematically monitor that the utilization of services is at the appropriate level. Upon receipt, the subcontractor's utilization determinations are imported into our medical management system. From here, the data is integrated into our standard set of clinical reporting where we monitor

subcontractor performance.

Subcontractor utilization data is measured against the subcontractor's historical data, expected performance and benchmarks to identify potential issues or areas of non-compliance. In addition, because WellCare does not delegate appeals, we carefully monitor appeals data to identify any negative trends with adverse determinations that would suggest problems with utilization of health care services. As issues are identified, we initiate focused audits to validate the appropriate application of medical necessity criteria and adherence to policies and procedures.

To supplement the review of submitted utilization data, we leverage data produced by our Quality Analytics team to identify trends in care caps suggesting under-utilization of services. Utilization management and care gap data are reviewed and analyzed regularly and discussed at quarterly business reviews between WellCare and our subcontractors delegated for utilization management. Information is also presented to our Utilization Management Committee to solicit feedback and drive actions to improve utilization and, ultimately, health outcomes.

Ensuring Delivery of Administrative and Health Care Services to Meet or Exceed all Standards

Monitoring of subcontractor performance is part of our Quality Improvement Work Plan. In collaboration with functional areas and Regulatory Affairs, we developed a standard performance scorecard (**Figure 3**) for our subcontractors. The scorecard provides for the regular monitoring of key performance indicators (i.e., turn-around times, percent of requests denied) to ensure delivery of administrative and health care services at or exceeding all established standards. On a quarterly basis, subcontractors must submit their completed scorecards by the 10th of the month following the quarter. Scorecards are submitted through a secure FTP site where they are systematically placed into the subcontractor's delegation folder for the assigned auditor. The auditor evaluates the subcontractor's performance over the past quarter noting any issues, trends or deficiencies. This information is then reported to the respective Quality Improvement and Utilization Management Committees. Subcontractors that fail to provide timely scorecards are immediately placed under corrective action as are subcontractors that perform below standards. As a process enhancement, beginning in 2016, subcontractors will also be required to supply the raw data to substantiate the report card metrics. The scorecards allow the subcontractors to continue to self-report key metrics while the raw data will allow WellCare to conduct yet another level of audit and oversight.

Figure 3

ENTITY: (NAME) STATE: (State) REPORTING QTR - 201x LOB: (xx)												
UTILIZATION MANAGEMENT												
	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
# TOTAL PRE-SERVICE REQUESTS												
# APPROVAL DECISION												
% APPROVED												
# DENIAL DECISIONS												
% DENIED												
# OF PRE-SERVICE DETERMINATIONS MADE WITHIN REQUIRED TIMEFRAME												
% OF PRE-SERVICE DETERMINATIONS MADE WITHIN REQUIRED TIMEFRAMES												
# OF PRE-SERVICE DETERMINATIONS MADE WITHIN REQUIRED TIMEFRAMES												
% OF PRE-SERVICE DETERMINATIONS MADE WITHIN REQUIRED TIMEFRAMES												
VENDOR COMMENTS												

Figure 4

In addition, all subcontractors delegated utilization or care management activities are subject

to further routine evaluation to ensure the delivery of administrative and health care services to meet or exceed all standards. We evaluate these subcontractors on 31 Key Performance Indicators (KPIs) across six weighted categories that include cost, delivery and support, flexibility and ease of doing business, contractual compliance, quality, and partnership. As reflected in **Figure 4**, we rate each subcontractor's performance on the KPIs using a five-point Likert scale. Concurrently, we invite the subcontractors to complete a self-assessment. We then meet with the subcontractors to review the results and discuss opportunities.

Ensuring Adherence to Required Grievance Policies and Procedures

As previously noted, under our Delegation Oversight policy and procedures, appeals and grievances are never delegated functions. WellCare retains operational control of required grievances policies and procedures. Subcontractors are required to manage any grievances they receive with the same vigor as we manage grievances submitted to WellCare.

Ensuring Subcontracts Comply with Reimbursement Rate Requirements

Our dedicated Claims Audit unit, a team independent of our Claims and Delegation Oversight teams yet highly integrated, is responsible for ensuring our subcontractors comply with reimbursement rate requirements. They do so using a variety of methods, including:

- **Contracts:** WellCare's contracts contain specific language detailing the requirements for reimbursement rates. The language specifies that subcontractors' contracts must not contain terms for reimbursement at rates that are less than the published Medicaid fee for service rate in effect on the date of service.
- **Claim Audits:** Annually, our Claims Audit team performs a financial accuracy audit of all subcontractors' delegated claims payment. As part of this review, the Claims Audit team checks for proper reimbursement at rates specified by the provider contracts and the contract with WellCare. If the subcontractor's financial accuracy and payment accuracy scores do not meet expected performance levels of 99 percent and 95 percent, respectively, a second audit is performed. If the re-audit produces unacceptable accuracy scores, the subcontractor is placed on corrective action and monitored through the Delegation Oversight Committee. ***Year to date for 2015, our delegated vendors are at 96.5 and 95.7 percent for financial and payment accuracy, respectively.***
- **Contract Enforcement:** WellCare uses the contract to enforce financial and payment accuracy requirements. We develop corrective action plans (CAPs), track adherence to these CAPs, and perform a second audit. Subcontractors who continue to perform poorly are subject to further disciplinary action including revocation of claims payment functions. For 2015, the relatively small number of subcontractors who did not meet required thresholds have been placed on a corrective action plan and are scheduled for reaudit.

Annual Evaluation of Subcontractors' Performance to Ensure Continued Contract Compliance

In addition to the ongoing monitoring described herein, at least annually, WellCare subjects subcontractors to formal audits to ensure continued compliance with contract provisions. Our delegation scheduling report is an automatic report produced daily. It identifies those subcontractors due for an annual oversight audit based on their last audit date. The report is routed to the appropriate audit coordinator's queue where he or she then sends the audit notification and tools to the subcontractor and schedules the audit. Once again our subcontractors are invited to complete a self-assessment. Once completed, the questionnaire and supporting documentation are routed to the delegation auditor for review. The delegation auditor then reviews the results of the questionnaire and performs a "virtual" onsite review of systems and processes using webinar capabilities. WellCare reserves the right to complete a full onsite audit for the annual review if warranted based on the subcontractor's performance.

Our Delegation Oversight Systems and Tools Support Compliance with State Medicaid Program Standards and Prevailing Local and National Medical Standards

Our Delegation Oversight team uses a set of proprietary, interactive audit tools to address the respective activities that are being delegated, as applicable. These tools are based on NCQA, state and federal requirements and are reviewed annually to ensure key regulatory requirements are being evaluated. Our audit tools are integrated with our compliance system maintaining document integrity and consistency. Furthermore, through the integration with our compliance system, we can invite subcontractors to complete documentation and assessments and route such activities in a highly trackable and auditable fashion. The following is a list of the comprehensive audit tools available:

- Business Continuity/Disaster Recovery (Global)
- Case Management
- Claims Processing
- Compliance, FWA, HIPAA, Incident Reporting (Global)
- Credentialing (including recredentialing)
- Member and Provider Service
- Disease Management
- Network Management
- Non-Emergency Transportation
- Pharmacy
- Provider Appeals
- Utilization Management

Our Delegation Oversight team uses C360 for a number of delegation-related activities including housing of audit tools, completion of audit questionnaires, document retention, and housing of corrective action plans. C360, a software-as-service solution, is the most widely used compliance, risk and governance solution in the health care industry. It features a collection of configurable modules as well as built in workflow and intelligent routing capability. In addition to C360, our delegation oversight team houses executed, written delegation agreements in a secure, shared repository.

Our Multi-Disciplinary Delegation Oversight Committee Governs Subcontractor Activities and Performance within Required Timeframes

WellCare's Delegation Oversight Committee is ultimately responsible for ensuring the quality of care, service, and compliance provided to WellCare members and providers by our subcontractors. The Delegation Oversight Committee provides continuous oversight of subcontractors' programs and performance through the regular review of data, reports, audit results, and corrective action plans. The Committee has the authority to revoke delegation or terminate services, if necessary. The Committee reports to the Quality Assurance and Performance Improvement and Utilization Management Committees as well as Corporate Compliance Committee and the Regulatory Compliance Committee of the Board of Directors. The Delegation Oversight Committee is comprised of representatives from Compliance, Clinical Services, Customer Service, Claims, Quality, Legal (non-voting member), Regulatory Affairs, Regional Markets, Finance, and Internal Audit (non-voting member).

SECTION IV.L CARE MANAGEMENT

58. Provide a comprehensive discussion of the MCO's care management program, including:

- Coordination of services using person-centered strategies.
- Interventions focused on the whole person.
- Management of co-morbidities.
- Incorporation of best practices for behavioral health.
- Member engagement in self-management strategies.
- Social determinants of health, including risk and protective factors for behavioral health concerns.
- Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services.

Provide case studies and experience from other states illustrating the MCO's ability to successfully address community differences in its care management approach.

(No page limit)

INTEGRATED, LOCAL, PERSON-CENTERED AND COLLABORATIVE: WELLCARE'S CARE MANAGEMENT PROGRAM

WellCare has developed our model of care around the principle that members have the best opportunity to reach their optimal health, wellness and recovery when they are served in partnership with high quality, financially aligned networks and have access to tailored care management services locally in their communities. Our care model is fully integrated to meet the physical, behavioral, pharmacy and psychosocial needs of our members with a special emphasis on social determinants of health, and is guided by data driven care management principles with interdisciplinary care teams (ICTs) to navigate the spectrum of clinical and social needs of our population.

WellCare's Care Management Program was built based on 20 years of experience working with members served through government-sponsored health care programs. Because we know that one size does not fit all, we built our care model on a modular architecture that is tailored to each individual state in which we operate with culturally-sensitive bolt-on programs to meet the unique needs of diverse populations and geographies. WellCare believes in establishing a foundation for each of our affiliates using evidence-based clinical guidelines and disease and wellness programs to drive high quality care for our members in their communities.

At the core of our model is a clinical philosophy of shared responsibility between the member, the provider and WellCare, where all participants drive toward improved outcomes. When the WellCare team developed our care model and tailored it specifically for our Heritage Health members, they did so first and foremost with an empathic view of the member. To forward this person-centered approach, our processes are built to assist members in understanding their overall health status, offering multiple channels for member engagement and embracing the empowerment of self-directed care.

A Nebraska Touch: Molding the Care Management Program for our Heritage Health Members

WellCare's care model is perfectly suited to meet the needs of Nebraska's enhanced vision for Medicaid modernization with certain key features including:

- **Field-Based Care Management Support:** With the addition of the aged, blind and disabled (ABD) and dually-eligible membership, we see a significant need to connect with people in their homes and communities to help them achieve improved health outcomes. To that end, we offer field-based care

managers, social workers and care coordinators to serve our highest risk members supplemented by telephonic outreach and support. These care managers will be located throughout the state to help reach individuals in remote, rural and frontier areas as well as the urban centers.

- **Integrated and Interdisciplinary Care Teams:** For the integration of behavioral health and pharmacy services to be meaningful, truly integrated care should be part of any solution. WellCare offers an integrated approach with behavioral health management conducted in house and behavioral health care managers working side-by-side with physical health care management teams.
- **Access to Social Services and Supports:** As more members with complex needs are folded into the program and more complex needs are covered, success is dependent on helping members navigate "the 80 percent of health care that happens outside the doctor's office." That's why WellCare offers an industry-leading proprietary approach to developing a social service network, referring members to those services, tracking outcomes and connecting with communities to support improved access to social safety net programs that help our members mitigate barriers to care.

A key feature of WellCare's Care Management Program is establishing specific concentrations on "super utilizers," members whose impactable conditions require additional attention for positive outcomes. These are often members with multiple complex and chronic conditions, often found in the ABD and dually eligible populations. Additionally, women identified with potentially high-risk pregnancies are routinely provided care management services through a sub-contracted entity as a base part of our care management approach.

In addition to deploying our base care management program which is ideal for ABD members, women with high-risk pregnancies, individuals with special health care needs and dual eligibles, WellCare has spent months meeting with stakeholders – members, providers, advocates and community organizations across the state – to align our programs and models to the needs of Nebraskans. Based on these meetings and an in-depth view of public health and other available data, we've identified opportunities to tailor the Care Management Program to place additional concentration on populations with very unique and specific needs. These include:

- Foster children, particularly those in out-of-home or residential placement
- Children with serious emotional disturbance (SED)
- Adults with serious mental illness (SMI)
- Native Americans being served in 638 Tribal Clinics

Additionally, WellCare has developed bolt-on strategies to support members who may be receiving care coordination because of their status in a home and community based services (HCBS) waiver or their connection to a patient-centered medical home (PCMH) without duplicating those services.

MEMBER STORY

Field-Based Care Management In Action: Why the Personal Touch Matters

A series of strokes left a 32-year-old member of our Florida affiliate, Staywell, with severe contractures and minimal verbal skills. She was confined to her bed because of mobility issues and needed help with daily living activities. She also has asthma, hypertension and vision problems. Care management was called to assist in getting physical therapy. Because Staywell uses a field management model of care, care manager Theresa visited the home to meet with the family. When she arrived, she found that the member's needs went beyond physical therapy. The member's rigid muscles and joints prevented her from being able to use a standard wheelchair because she was unable to sit. Her family was using a stretcher to move her, which limited her ability to get to medical appointments, and her overall health suffered. The lack of mobility was also impacting her quality of life. "She had to lie in bed all day. She couldn't come out and be with the family, or sit and watch TV. We were dealing with a lot of isolation," Theresa said. Theresa noticed a Hoyer lift in the apartment, but neither the mother nor the home health aide knew how to use it to move the member. Theresa also noticed the member did not have a special air mattress to reduce her risk of pressure wounds. Theresa worked with the member's social worker to get a physical therapist to come to

MEMBER STORY

Field-Based Care Management In Action: Why the Personal Touch Matters

the home to provide therapy and educate the mother and home health aide in using the lift and customized wheelchair to enable the member to spend time with the family in other parts of the home and to enjoy the outdoors. Theresa also assisted in obtaining needed referrals and appointments with a pulmonologist, cardiologist, podiatrist, dentist and ophthalmologist to address the member's other health needs. She attended the primary care appointment with the member and her mother to ensure they were able to understand the doctor's instructions and to help coordinate care to ensure the proper specialists were in place. ***Our care manager was instrumental in helping to wrap services around this member and her mother to allow the member to continue to live at home.***

THE WELLCARE CARE MANAGEMENT PROGRAM AT WORK: A CONTINUOUS PROCESS

WellCare's Care Management Program is a continuous process of stratification, assessing member needs and goals, development of individualized care plans, implementation of care plans and monitoring compliance and efficacy as seen in **Figure 1**. This process is supported by a highly trained staff of care management professionals that includes nurses, social workers and care coordinators from a variety of backgrounds and with a diverse set of expertise. Those professionals are supported by our integrated medical and pharmacy leadership.

Figure 1

Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services

All active members are assigned a score, based on a proprietary scoring algorithm that places them into four levels of care management need. In addition to being assigned a score, the members are flagged when specific conditions exist that are likely to be positively impacted by care management. In the first 30 days of a member's enrollment, this score is derived from a combination of initial health risk screening data, pharmacy utilization data and hospital discharge data. After 30-60 days of enrollment, and on a rolling annual basis, the score is refined with any historic medical and pharmacy claims data that has been captured. The scoring of members is based on three primary drivers: clinical severity, utilization, and cost as described below.

- **Clinical severity:** This portion is based on the Chronic Illness and Disability Payment System (CDPS) model, a diagnostic classification system developed by the University of California, San Diego. This Statistical Analysis System model classifies every diagnosis code on a claim and assigns a score based on the severity of the diagnosis. The CDPS model also examines pharmacy utilization as a component of risk scoring.
- **Utilization:** This portion of the model uses a number of utilization indicators and applies a weighted score based on input from the clinical services team. The metrics tracked are hospital admissions, emergency room visits, PCP visits, specialty visits, acute admissions, home health visits, and rehabilitation visits.

- **Cost:** The cost portion scores each member based on his or her relative, normalized per member per month (PMPM) cost as compared to the other members within the program. The cost component looks at inpatient, outpatient and professional costs.

Identifying Members Eligible for Care Management Programs through Other Channels

Data mining and risk stratification are effectives way to identify members with the greatest need for care management. We will also rely on non-claims-based data identification methods including referrals and event triggers (e.g., transitioning into a new care management organization, discharge from an inpatient facility, crisis call). These non-claims-based methods are outlined in **Figure 2**.

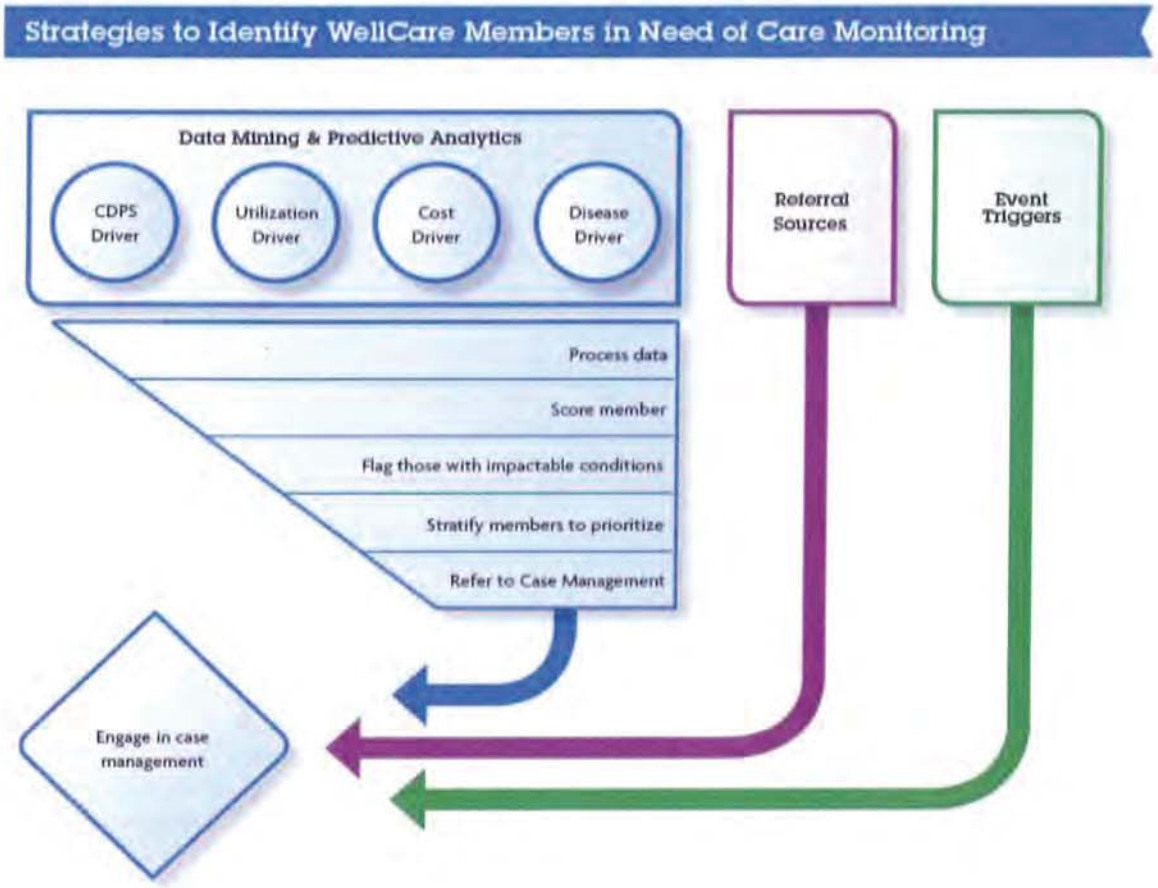
Figure 2

NON-CLAIMS BASED IDENTIFICATION SOURCES
Referral Sources
State-provided special needs codes on the 834 enrollment file
State-provided reports (i.e., lead file, special health care needs file)
Member or caregiver requests
Providers
Prior authorization
Discharge and retrospective review
Disease management
Community program referrals (No wrong door e.g. AAA, ARC, day care centers)
Nurse Line and Crisis Line
CommUnity Assistance Line
Event Triggers
Transition of care initiated by another care management organization
Member completion of health risk screening – initially or annually (results from survey)
Other
WellCare reports (i.e., frequent emergency room utilizers, pharmacy usage)

In addition to the components above, algorithms are used to identify specific impactable conditions, such as pregnancy, depression, asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disorder, diabetes, hypertension, AIDS/HIV and children with special needs. The condition-specific model stratifies the results for each member into a clinical risk group based on diagnosis, procedures, and pharmacy claims information. Those in the higher clinical risk groups are referred to care management for further evaluation.

In cases where we don't have claims history, we use an initial health risk screening (conducted by telephone during member welcome calls and included in the member welcome packet) to identify urgent and special health care needs and place members in risk levels. The full continuum of identification strategies are demonstrated in **Figure 3**.

Figure 3



Through these various techniques, every member is placed into one of four care management levels. Those in the higher clinical risk groups are referred to care management for further evaluation. Each level is described below:

- **Care Management Level 4:** Members in Level 4 are our highest risk and most complex members. These members are often catastrophic, high-risk, and high-cost and require special assistance to negotiate health and social services systems. These members require the highest level of care management intensity. Care management of these members is field-based with care managers meeting members in their communities. The care manager assesses the member's health and develops a care plan aimed at stabilizing the member. The care manager contacts the member frequently, at least once a week, and actively assists with transition of care, appointments, referrals, transportation, forms and other paperwork and engages with various health and social service providers. Because of the clinical profile, the care manager reviews and revises the member's care plan at least every two weeks or more frequently as needed.
- **Care Management Level 3**: These members have moderately high complexity. The care manager assesses the member's health and develops a care plan aimed at reducing their risk level. Care management is often telephonic but face-to-face interactions also occur. The care manager contacts the member at least once every two weeks and assists with referrals, transportation, and community-based services. The care manager reviews and revises the member's care plan at least every three weeks or as the member's health status changes.

- **Care Management Level 2**: These members are moderately complex. The member needs a moderately low level of interventions; therefore, care management outreach is telephonic. The care manager assesses the member's health and develops a care plan aimed at maintaining or reducing his or her risk level. The care manager assists with referrals, transportation and community-based services. The care manager reviews and revises the care plan at least once a month or as the member's health status or goals change.
- **Care Management Level 1**: These are our members with the least complexity and lowest risk. These members are stable and have only a few interventions on their care plans. The member requires only periodic support and monitoring; therefore care management outreach is telephonic. The care manager assesses the member's health and ensures that the member has information about public assistance programs for health and social services which would benefit the member and to which the member may be entitled. The care manager contacts the member at least once a month to assess status and progress against goals. The care manager updates the member's care plan monthly or as the member's health status or circumstances change.

Focusing on the whole person to understand and fully assess individual needs and goals

Once stratified, members are assigned to a care manager to match their needs. We offer a variety of care management supports depending on individual risk levels, including field based or telephonic care managers. Based on the additional assessment, outlined below, we also have sub-specialties within those care manager teams for behavioral health. For members in the lower risk levels, we have telephonic teams that focus on impactable chronic conditions, sometimes referred to as disease managers. In Nebraska, children in foster care will have access to Foster Care Care Managers (FCCM).

Care managers connect with the member to complete a comprehensive Health Risk Assessment (HRA) of the member's medical, behavioral, socio-economic, psychological, environmental and functional needs within 30 days of assignment to a risk level. The assessment is critical for the care manager to assess and gather information related to the current or proposed care plan

The goal of this stage is to optimize health and well-being for each enrolled member by:

- Assessing the member's total functional capacity, health status and behavioral health over time through the comprehensive HRA
- Supporting informed health care consumerism and the member's ability to self-manage
- Identifying urgent and short-term needs to accelerate access to needed services and care
- Providing individualized health education to assist the member set and meet health and personal goals
- Evaluating the member's environment and natural support network
- Identifying social barriers and linking members to corresponding social safety net services
- Identifying the member's support structure and engagement with providers
- Assessing member placement and ability to live in the least restrictive setting of their choice
- Assessing palliative care needs and end of life care planning, as needed

Additionally, because WellCare is an integrated plan, we have developed additional assessment opportunities to make sure we are assessing for behavioral health conditions and reacting appropriately based on a member needs. To that end, we use the following validated screens as part of the comprehensive assessment process and throughout our Care Management Program to identify and assess a member's mental health and substance use conditions:

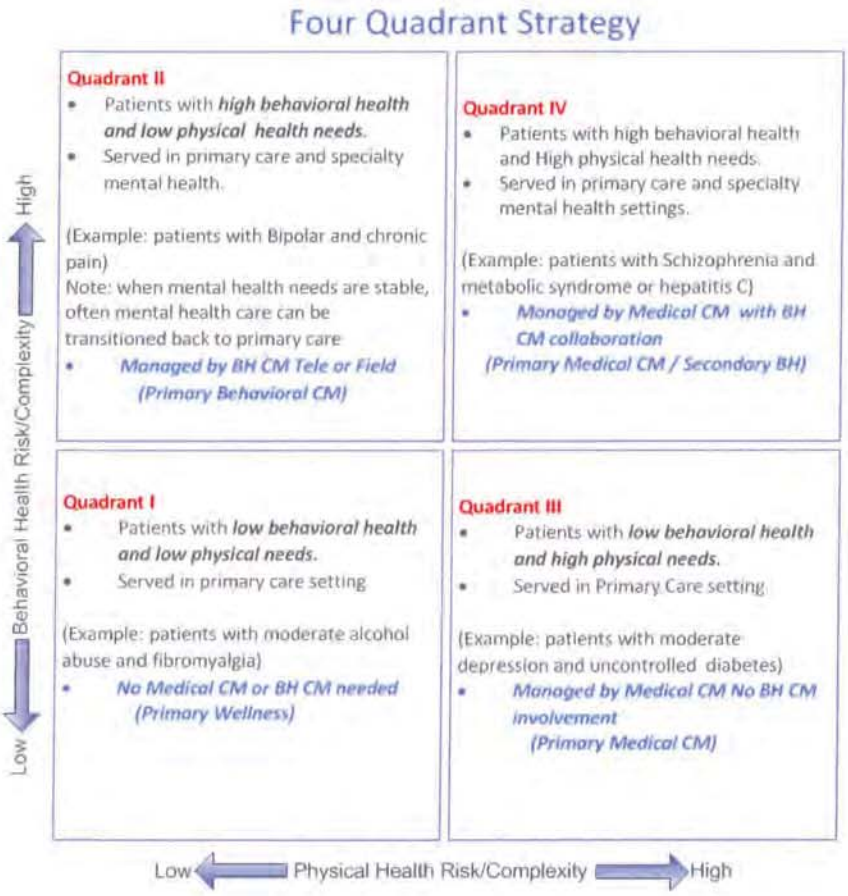
- CAGE/CAGE AID (Drug and alcohol use screening tool for individuals 16+)
- CRAFFT (Screens for high-risk alcohol and other drug disorders for individuals ages 12 to 21)

- PHQ-9 (Depression screening tool for individuals age 13+)
- Edinburgh Postnatal Depression Scale (EPDS)

For each of these screens, we have trigger points at which members are referred immediately for behavioral health care management. If members are identified as experiencing a serious mental health crisis, our care managers will immediately implement our crisis call protocol to ensure member safety and further crisis assessment.

Our care management team also uses a four quadrant model to appropriately assess the best approach to care management based on the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Four Quadrant model. **Figure 4** represents our model, which connects individuals to care management based on the member's needs at any point in time in his or her path to recovery and resiliency. The level of care management is assigned based on the results of the comprehensive assessment and the condition currently driving the primary needs of the member.

Figure 4



Engagement of the Member by the Interdisciplinary Care Team

At-risk members with behavioral health needs fall into either Quadrant II or Quadrant IV. Members assigned to these quadrants receive integrated care management as described below.

- **High Behavioral Health Needs/High Physical Health Needs:** Members in Quadrant IV receive field-based care management. The physical health care manager (nurse) is the primary care manager supported in collaboration with the behavioral health case manager. The individual is served in both primary care and specialty mental health settings, with the goal being to provide the most integrated care possible.

- **High Behavioral Health Needs/Low Physical Health Needs:** Members in Quadrant II receive either telephonic or field-based care management from an interdisciplinary care team. The behavioral health care manager is the primary care manager supported by a physical health care manager, disease management associate, community advocate, outreach associate, and associates from the utilization management team who regularly support the care management team through grand rounds, alert of member admissions, assistance with discharge planning and participation in ICT meetings if there are services that need to be created and authorized.

Care management assignment is not static. The member's needs change throughout his/her enrollment in care management, and when a behavioral health issue is the driver of change, the behavioral health care manager will lead the team to drive solutions that are most responsive to the individual member's current and critical needs.

Person-Centered and Culturally Competent: The heart of the care plan development phase

Based on the comprehensive assessment, the care manager will work with the member to develop an individualized care plan according to his or her needs. With input from the member or caregiver and the Interdisciplinary Care Team (ICT), an individualized care plan will be developed with prioritized goals and actionable interventions.

WellCare's information technology (IT) system provides care managers with evidence-informed tools to populate standardized goals based on the member's condition. These tools guide the process while care managers customize goals and service plans based in individual needs of the member as part of our person-centered planning process. Care managers also examine historical data and care gaps to inform the care plan and ensure members are getting the preventive and follow-up care called for in the Clinical Practice Guidelines to manage their conditions.

WellCare's care managers are trained in evidenced based engagement strategies such as motivational interviewing, which is a goal-directed, person-centered counseling style for eliciting behavioral change by helping individuals explore and resolve ambivalence. Motivational interviewing is applied to a wide range of problem behaviors related to alcohol and substance abuse, as well as health promotion, medical treatment adherence and mental health issues. This method of interaction allows the care manager to engage the member and allows the member to engage in setting realistic and attainable treatment goals.

Through these methods, we incorporate the member's perspective on his or her health, his or her level of health literacy, cultural and faith-based beliefs, and his or her personal goals for health status. In this regard the member's goals are expressed in personal terms, such as, "I want to be able to walk to the park without losing my breath," instead of, "I want to better control my COPD." We seek to frame goals in meaningful statements that fit the person.

The care plan is designed to be culturally appropriate and consistent with the abilities and desires of the member or caregiver. The personalized care plan includes the following:

- Timeframe for re-evaluation
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfers
- Collaborative approaches to be used, including family participation
- Self-Management Plan
- Development of a schedule for follow-up and communication with members

The care plan process is accessible to members who have disabilities or have limited English proficiency, and reflects the cultural preferences of the member. The care plan is developed in accordance with applicable quality measures and utilization review standards. WellCare provides a copy of the care plan to the member's PCP and other significant providers and gives the member an opportunity to review the care

plan. WellCare is developing a single use URL system that will allow individual member care plans to be available through a secure portal to streamline sharing with providers.

WellCare requires that care managers review care plans as frequently as needed based on the member's clinical conditions, but not less than monthly. The care manager reviews the plan to determine the status of all existing activities/interventions and to ensure actions are completed by the established time frames.

MEMBER STORY

Person-Centered Care Planning at Work

A WellCare of Georgia member would not accept blood or any blood parts (including white blood cells) from another person due to her religious beliefs. Carrying a high-risk pregnancy, the member was in need of an obstetrician, a neurologist and a behavioral health provider who could coordinate complex care needs that included extensive medication lists, effective prenatal care and a healthy pregnancy and delivery, while still honoring her religious preferences. WellCare of Georgia was able to identify an obstetrician who accepted the member and respected her religious preferences. Through an effective partnership between her WellCare care manager and a team of specialists, there was coordination of numerous medications, as well as peer-to-peer consultations between her OB provider, neurologist and psychiatrist. The member's pain and anxiety concerns were respected and effectively addressed. The outcome of everyone's efforts was a healthy, full-term baby boy

IMPLEMENTING THE CARE PLAN

Through regular in-person contact, telephonic contacts and educational support, WellCare care managers build and maintain relationships with members, while continuously assessing the needs, safety and well-being of the members. The goal of WellCare's Care Management Programs is to stay ahead of the member's functional deficit, illness or behavioral health trajectory, to identify issues that can be prevented and improved, to initiate appropriate interventions, and to eliminate or mitigate complications, including the need for preventable emergent care and unnecessary hospitalizations. Medical, behavioral health, custodial and social service resources are optimized to better facilitate care gap closure by accessing local services.

Staffing and training Care Management teams to Carry Out Care Management Functions

Our Care Management teams are staffed to implement care management strategies based on the level of care management they are providing.

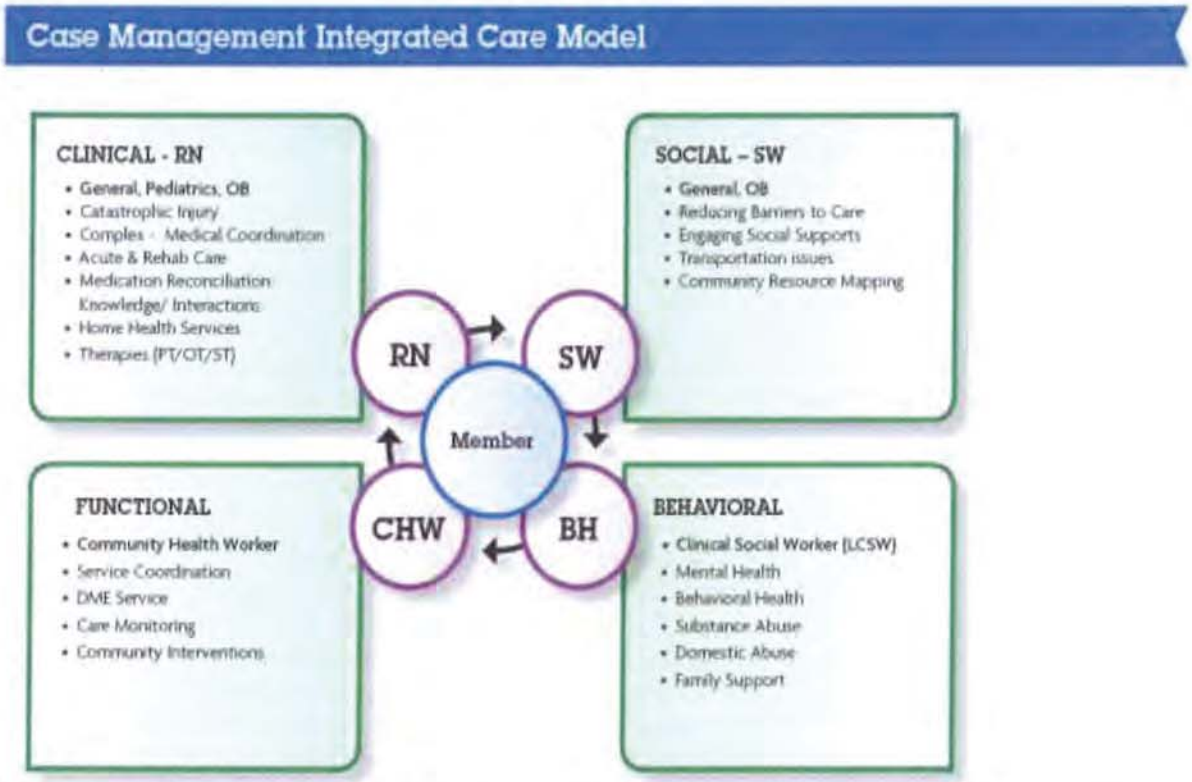
- The Field-Based Short Term Case Management (SCM) Team, which serves the highest acuity members, consists of registered nurses, social workers and care coordinators. The team ratio includes 4 to 5 registered nurses, 1-2 Social Workers and 1-2 Care Coordinators driven by geographic size and need. Each team maintains an average caseload of 30 cases at a time with an average length of time in the program of 60-90 days. The team undergoes an extensive 4-6 week training program.
- The telephonic and complex case management teams for medium risk members include registered nurses, social workers and care coordinators. Caseloads average 30 cases per care manager for short-term management with 60 days average time in program and 60 cases per care manager for Chronic Case Management with 90 days average time in program. The team undergoes an extensive 4-6 week training program.
- The disease management team which serves the lowest risk members and focus on individuals with single chronic conditions includes registered nurses, care coordinators and health coaches. They average 100 cases per care manager with 90 days average length of time in the program. This team undergoes 4 weeks of training.

Management of Co-Morbidities

A key feature of WellCare's approach to care management is implementing plans for members with co-morbid and complex conditions. Our teams at the higher risk levels are specifically trained and structured

to work in an interdisciplinary fashion to support multiple member needs. We have a fully integrated staffing model to help us manage across conditions as shown in **Figure 5.**

Figure 5



The Interdisciplinary Care Team (ICT) also plays a key role in managing members with co-morbid conditions. Behavioral health specialists work alongside their medical and social worker counterparts on our ICTs, which include registered nurses (RN), behavioral health professionals, and other health care professionals. If a member has primary behavioral conditions, the member will be assigned to a behavioral health specialist (for members with a psychiatric diagnosis or substance abuse issue). If there are secondary co-occurring conditions needs, the mental health professional will work with the primary medical case manager to manage the member across the continuum to confirm the member is connected to the necessary services and supports within the member's community. For members with both high behavioral and medical needs, WellCare's model of care can be adapted by having both behavioral and medical care managers co-lead the team.

Incorporation of best practices for behavioral health

We believe that a fundamental best practice for behavioral health is having a truly integrated approach to care management assuring our members receive their medical, behavioral, pharmacy and social services in a seamless, coordinated and complete fashion.

Through our integrated behavioral health program, WellCare served more than 200,000 members in eight Medicaid states in 2014.

Our approach to a recovery-based, trauma-informed model of care means that we consider and involve families and natural supports, enabling members to have every opportunity to live full lives in the communities they live. We understand that sometimes the best outcomes for people are based on the support and engagement of the people around them. Whether

the member is an adult or a child, identifying and including people who support the member at home and in the community is critical. We understand that our members have certain rights to privacy which we honor by obtaining the proper consents when necessary. With proper consents, our treatment planning process includes family members, designated representatives and, in some cases, friends, peers or significant others identified as key individuals that can support the treatment and recovery process for individuals. It is often through working with advocacy organizations that we are able to identify the best strategies to utilize and are able to secure a community-based support system for people who do not have family or anyone else to help them. Our approach is to work with relevant locally-based stakeholders to deliver and guide us with designing our behavioral health care delivery process. We will interface with stakeholders using the following strategies:

- Consult with mental health, disability and substance use advocacy groups
- Learn the local community resources and, through our advocacy and outreach activities provide support and facilitate connectivity between local communities and our health plan
- Work with, and to the extent possible contract with, peer support specialists to manage the needs of SMI members
- Develop a clinical advisory council made up of providers throughout the state that advise and guide us on clinical best practices, assist with addressing provider related issues and problems in the service delivery system
- Employ staff that are individuals in recovery or family members who are qualified to perform duties of our open positions as well as hire peer or family advocates directly on staff to serve in advocacy/support roles

Four programs highlight our engagement approach with families, natural supports, advocacy organizations and network providers.

- **Behavioral Health Homes:** WellCare seeks to build on the strong efforts Nebraska has undertaken to adopt Patient Centered Medical Homes and current pilots for integration to support Behavioral Health Homes (also referred to as Integrated Health Homes (IHH). We have developed a detailed program description, clinical and payment model for these IHH programs and have already had early conversations with providers in Nebraska interested in pursuing integration.
- **Peer Support**: To promote recovery and empower our members with SMI, SED and SUD diagnoses, we will use peer support specialists who are living in recovery and can connect on a personal level with members about their illness and assist them in navigating the system. We will collaborate with and support existing peer support models including integrated health homes, Recovery/Wellness centers, peer crisis services and peer support/counseling services. We strive to employ individuals in recovery to work with our members in CM or member engagement roles.
- **Family Involvement**: Like peer support, natural supports are critical to recovery; therefore, with member consent, our community-based care managers connect with families and caregivers to engage them in the treatment planning process. We will utilize best practices, like family psycho-education, and we will assist families in understanding their family member's illness and how they can support the member on the road to recovery.
- **Telehealth**: WellCare is offering to support and expand telehealth opportunities, particularly for behavioral health, to address shortages throughout the state in access to behavioral health providers. Our strategies support reimbursement methodologies that promote telehealth, grants for technology as needed and supported by data and introduction of direct doctor-to-patient telehealth contact through emerging platforms.

MEMBER STORY

Behavioral Health Interventions Drive Improved Outcomes

A 12- year-old member of WellCare of Georgia had a history of inpatient admissions to an acute psychiatric hospital and crisis management unit. Upon being assigned the case, our care manager contacted the member's mother to engage her in the care management process. In collaboration with the mother, the member, the psychiatric residential treatment facility and a community-based intensive family intervention specialty provider, the WellCare of Georgia care manager developed a transition plan from residential treatment to community based services. The individualized care plan included:

- An intensive in-home family therapy and skills building treatment program that focused on behavioral modification, safety plan and compliance provided by the IFI team
- A safety and participation contract with the member and the mother
- Coordination of medication management with the treating psychiatrist
- Regular scheduled follow-up communication with the care manager

As a result of this intervention, the member engaged in his care, attended appointments and adhered to his medication regimen. After three months in treatment, the member had not been readmitted to an inpatient facility. He was attending school regularly, had passing grades, and was no longer demonstrating explosive behaviors.

MEMBER ENGAGEMENT IN SELF-MANAGEMENT STRATEGIES

Our Care Management Program was built to focus on assisting members in understanding their overall health status and embracing the empowerment of self-directed care. Members in our lower risk levels and those emerging from higher risk levels into maintenance continue to be supported through self-management strategies.

A member may be referred directly to the Disease Management Program or referred upon completion of higher levels of care management. The Disease Management Program staff has full view of the member's assessments, case notes and health care claims to deliver education, guidance and support for the primary chronic condition for which a member may need additional support. The six key chronic conditions that are addressed in the Disease Management Program are:

- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes
- Hypertension

Members in the Disease Management Program are offered supportive disease specific educational materials from our vendor partner, Krames, written in easy to understand language for better management of their conditions. Upon completion of the Disease Management Program, the member is offered supplemental condition specific mailings twice a year via mail as long as desired.

Additionally, we offer a number of programs to give members tools to direct their own care outside the formal care management program. Some of those include:

- The Healthy Behaviors Rewards Program offers wellness incentives such as gym memberships or smoking cessation incentives.
- The Succeed Snapshot is a web-based health screening available online that members can take in the comfort of their own homes and at their own pace.
- Cobalt Therapeutic Intervention is a web-based program for members with behavioral health needs to access counseling services online to drive their own recovery as they see fit.
- Health Coaching Program is available to support members who desire to address weight management or smoking cessation. These programs are designed to be offered as a unique program or in collaboration with Case or Disease Management Program.

- Partnerships with community programs are a core part of our Health*Connections* program. Through these community activities, we support a wide range of community-based health and wellness activities aimed at empowering members to lead healthier lives.
- The 24-Hour Nurse Line is available for members to access a live nurse at any time to discuss any health concerns.
- The 24-Hour Behavioral Health Crisis Line is available for members to access for crisis or other needs.

INTEGRATING SOCIAL DETERMINANTS OF HEALTH

WellCare deploys an industry-leading proprietary approach to connecting members with social services to help address the social determinants of health that impact their health outcomes. This program, known as Health*Connections*, is integrated into our care management program, but also has its own staff to support care managers and to help members navigate social services resources.

Our integrated care management program is based on identifying the needs of our members; outreaching to them where they live; understanding how they prefer to engage with the health care system; facilitating their access to care; and helping them whenever, wherever and however they need us. Our community outreach associates are hired locally and have knowledge of the community including community services and partners. These associates are trained on compliant and effective engagement with prospective enrollees and members. Our community outreach department will support our integrated care management program through dissemination of information and education related to programs offered by the state of Nebraska and community organizations. Specific goals of the community outreach department include educating target audiences about the availability of health care coverage, and providing sufficient information to promote and encourage enrollment and retention within the program.

In Kentucky, we participated or sponsored 713 events and activities in 2014 with nearly 632,000 individual community touches.

Activities designed to achieve our community outreach include:

- Participation and sponsorship of educational events and health fairs
- Dissemination of MLTC-approved outreach materials
- Hosting table top events at approved community venues
- Partnering with organizations that have a primary focus on the well-being of children, families, the elderly and special populations
- Increasing awareness within the provider community to promote referral opportunities into the program
- Providing wellness information through social media, such as Facebook
- Promoting cultural awareness to reduce barriers to program access

In 2014, WellCare participated in or hosted more than 5,000 community activities reaching more than one million community stakeholders. These included peer support groups, children's dental days, car seat safety, healthy food access programs, baby showers, homeless outreach and more. WellCare also reached community stakeholders from diverse cultures and backgrounds including African American (299,000), Asian (221,000), Hispanic (260,000), Native American (13.000), and Native Hawaiian (12,000) cultures as well as many segments within the disability community (195,000) across more than 175 counties in seven different states.

WellCare intends to bring this focused support to the 93 counties and several communities in the state of

Nebraska. To this end, we have met community stakeholders from across the state to identify opportunities for collaboration. Many of these organizations host activities and events within their local communities. In meeting with these partners, we learned about several initiatives that offer opportunities to connect with prospective members, current members and the community-at-large and share information about the Medicaid program changes. WellCare has received letters of support from our community partners including letters from Break the Cycle Crisis Center, Inc. and Nebraska Children and Families.

MEMBER STORY

The Power of Integrating Social Service

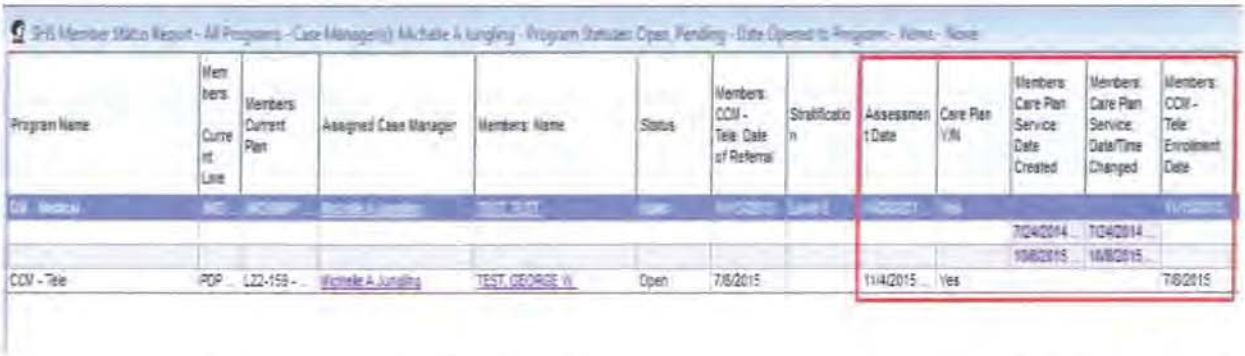
Vivian, a WellCare of Kentucky field service coordinator, was assigned a 63-year-old Medicaid member who had been recently diagnosed with Lewy body dementia. The disease had already caused the member to have difficulty with mobility, incontinence and memory loss. It was also making it very challenging for the daughter to serve as the mother's primary caregiver. With the goal of keeping the member at home, Vivian referred Hospice Care Plus to provide palliative care. She then educated the daughter on what to expect as the disease progresses and provided her with ways to adapt to the member's changing physical and mental capabilities. Additionally, Vivian learned that the daughter did not have a way to check the member's blood pressure, so she ordered her a blood pressure monitor and educated the daughter on the importance of using it daily. She also ordered a bedside commode and incontinence supplies.

Vivian then turned to WellCare's Health*Connections* Referral Tracker (HCRT), which includes a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She started with Kentucky Vision and helped the daughter fill out an application for glasses for the mother. The daughter was also given a list of local resources for food and utility assistance, and was provided with local medical transportation assistance to help the member get to her medical appointments. Vivian educated the daughter about additional benefits available to the member, including a behavioral crisis line and a 24-hour nurse line. Through Vivian's efforts, the daughter now has the proper medical equipment, and access to food and financial resources to ensure the member's dignity and safety. Further, palliative care services will assist the member's daughter with the member's care and allow her to transition into hospice when appropriate. These efforts are allowing the member to stay at home with her family for as long as possible.

Monitoring effectiveness of Care Management: The Final Step in the CM Process

WellCare utilizes reporting to measure effectiveness of programs, productivity and member outcomes. Records are reviewed regularly to ensure compliance with various requirements such as member outreach, updating of care plan, and staffing ratios (as shown in **Figure 6**). Managers are able to identify training gaps or needs through review of this documentation; ensuring members are progressing towards care plan goals. In addition to reviewing daily caseload reports, clinical leadership and our health services training specialist generate monthly and quarterly reports to monitor performance, including but not limited to the number of assessments and care plans completed within required timelines, case file and clinical documentation.

Figure 6



Program Name	Members Current Line	Members Current Plan	Assigned Case Manager	Members: Name	Status	Members: CCM - Tele: Date of Referral	Stratification	Assessment Date	Care Plan Y/N	Members: Care Plan Service: Date Created	Members: Care Plan Service: Date/Time Changed	Members: CCM - Tele: Enrollment Date
										7/24/2014	7/24/2014	
										10/8/2015	10/8/2015	
CCM - Tele	PDP	LZZ-159 -	Michelle A Jungling	TEST, GEORGE W	Open	7/6/2015		11/4/2015	Yes			7/6/2015

Quarterly reports include member satisfaction with the care management program, readmission rates and number of members enrolled in care management programs. This information is then analyzed and brought to the QIC and the Chief Medical Officer for discussion of the effectiveness of past initiatives and creation of any new processes needed to improve outcomes.

Our Medical Management Platform (MMP) allows for real-time reporting; providing managers reports such as caseload ratios, overdue assessments, contact frequency and care plan completion/updates. Reports may be at the individual case manager level, rolled-up by manager or aggregated for the entire department for senior leadership. In addition to the ongoing chart audits, care management managers monitor clinical performance through regular one-on-one supervision. Throughout the year, the manager does "ride alongs" with field care managers to monitor not only the assessment process but also the softer skills of interacting positively with our membership. On an ongoing basis, clinical leadership reviews utilization, quality and customer satisfaction and to identify gaps in service, systemic performance issues, noncompliance and member dissatisfaction. Using the information gleaned from these reports, WellCare develops strategies to remediate issues and improve the quality of care for our members.

Getting Results: Case Studies and Experience from Other States

WellCare has been piloting the kind of Field-Based Short Term Care Management we are proposing to bring to Nebraska in four Medicaid markets – Kentucky, Florida, Georgia and Illinois, with Kentucky and Florida being the longest running of those programs. So far, our results show that the investment in improving member's lives and meeting them where they are is paying off.

For Level 4 members in the Kentucky affiliate, we have seen a 31 percent reduction in overall per member per month costs primarily driven by a 48 percent reduction in inpatient care which was offset by small increases in pharmacy costs (utilization) and outpatient care. Similarly, Level 3 members with four or more chronic conditions managed by our Kentucky field team demonstrates a 22.3 percent reduction in per member per month costs driven by a 35.3 percent reduction in in-patient utilization which is offset by increases in outpatient and professional services utilization.

For Level 4 members in the Florida affiliate, we have seen a 37.5 percent reduction in overall per member per month costs. This is primarily driven by a 46 percent reduction in In-Patient Care which offset by small increases in Pharmacy costs (utilization) and outpatient care. Similarly, Level 3 members with four or more chronic conditions managed by our Florida field care management team demonstrate a 38 percent reduction in per member per month costs driven by a 52 percent reduction in inpatient utilization which is offset by increases in outpatient and professional utilization.

Improved member satisfaction

Additionally, members who receive care management services from WellCare are overwhelmingly pleased with the experience as shown in **Figure 7**. For 2014, the following two questions provide an overview of key member satisfaction results:

- Question 1: Overall, were you satisfied with WellCare's care management services you received?
- Question 2: Were you satisfied with the services that your care manager gave you?

Figure 7

WellCare's Member Satisfaction Results					
2014		Q1	Q2	Q3	Q4
Question 1	Total Surveyed	1,138	2,833	4,402	3,830
	% satisfied	97%	97%	97%	97%
Question 2	Total Surveyed	1,128	2,825	4,381	3,797
	% satisfied	98%	98%	98%	98%

Best Practice Example from Other States

In Kentucky, we have implemented a specialized program aimed at keeping children with autism out of institutional care. The WellCare Autism and Developmental Disability Special Case Management Service was developed to directly address a long history of members with autism and other developmental disabilities and their placement in inpatient acute facilities. The members identified for this service had a history of inpatient acute facility placement for three to four years with little access to any community-based placement. At the time of WellCare's involvement, these members were at ages 11, 12 or 13, meaning these members had lived in a facility for almost one-fourth of their life. WellCare was determined to search for alternatives to provide these members with appropriate treatment in the lowest level of care that matched their individual needs. A specialized team of WellCare of Kentucky care managers who are focused on children in foster care partnered with the Department of Community Based Services with the goal of finding treatment and placement options for these members to move them from a primary inpatient acute facility environment (many in out of state facilities) back to homes in the community. Partnering with a therapeutic foster care provider with the right funding flexibility from the state allowed us to increase options for these members. Using Trauma Informed Care models, we were able to connect these children with providers who understand their specific needs.

The outcomes have been significant. On average, individuals in the custody of the state of Kentucky will change placements 3.2 times per year. Because of this program, some of these members have lived in one home, in the community, for more than a year. These members also have key relationships within their community. In addition to their foster care parent and their service providers, they are now connected with their school, with their church, and within other social groups. Some members have been able to reconnect with family members whom they have not seen for several years.

The costs savings for the state have been significant as well with a 43 percent total decrease in costs for impacted members comparing six months prior to six months after the interventions.

We are basing our Nebraska foster care management approach on the successful structure of this program in Kentucky.

SECTION IV.L CARE MANAGEMENT

59. Describe the MCO's approach for identifying members in need of care management services, including:

- The proposed process for providing a health risk screening to all members upon enrollment to identify and assess members potentially eligible for care management services, including those who have or are likely to experience catastrophic or other high-cost or high-risk conditions.
- A description of the algorithms and methodologies the MCO will use to identify members potentially eligible for care management.
- The proposed process for conducting health risk assessments for members identified as potentially eligible for care management. Submit the proposed health risk assessment template that the MCO plans to use.

(Page limit 5 pages)

WellCare's Approach to Identifying Members in Need of Care Management

The first steps in our integrated, local, person-centered and recovery-focused model of care are appropriate identification and stratification of members who would benefit the most from the various levels of care management services we offer. Identification is conducted using a number of tools, including, but not limited to:

- Data mining and application of algorithms to assign case management based on member experience
- Initial Health Risk Screening
- More in-depth Health Risk Assessment
- Member, provider, agency or other stakeholder referral or request for services
- Internal referral
- Pre-identified special health populations, such as high-risk pregnancies or children in foster care

WellCare's Process for the Initial Health Risk Screening

The initial health risk screening (HRS) provides a snapshot of the member's needs and identifies those with special needs to further define the appropriate level of assessment and intervention. It is an integral component of the clinical assessment process. The initial HRS identifies the member's basic needs and conditions. When coupled with our predictive modeling capability, the HRS provides sophisticated member stratification and assignment to the most appropriate care manager based on condition and identified risk factors. WellCare's process for conducting the initial health risk screening will begin immediately upon enrollment.

All members will receive a hard copy of the written health risk screening in their new member welcome packet which is mailed to the member within 10 days of enrollment. The materials the member will receive will instruct the member on how to complete and return the written health risk screening. The materials will also inform the members that they may complete the survey via the telephone or web and will provide easy-to-follow instructions regarding how to do so. We will also attempt to conduct a health risk screening during the initial welcome call.

The health risk screening call contains specific questions about health conditions and members are prompted to respond yes or no if they have been diagnosed with certain conditions including diabetes, cancer, depression, alcohol and drug use, AIDS, heart failure, and mental health issues. The questions also are designed to identify any urgent or crisis needs to help stratify members for immediate short-term care management services. Members are also asked about other services they receive including physical

therapy, hospice, home health and durable medical equipment such as oxygen or a hospital bed. If the member is female she is asked about pregnancies and whether or not she is currently pregnant. The final section of the assessment focuses on lifestyle choices such as healthy weight, diet, stress management and overall health.

Certain members identified in the 834 enrollment file as having special needs, such as aged, blind and disabled, Foster Care children and waiver services recipients will bypass the HRS and be directly referred to care management for outreach and completion of the more detailed health risk assessment. Care managers will make three attempts to reach the member over different days of the week and different times of day to complete the assessment via telephone or schedule an appointment to meet in person. If the member cannot be reached, a letter will be mailed letting the member know that a WellCare care manager is attempting to reach him or her and asking the member to call us as soon as possible. Concurrently, the care manager will contact the primary care provider of record or any other providers that may be caring for the member in an attempt to get more accurate contact information.

Foster children, as identified in the enrollment files, will automatically be routed to our Foster Care Care Management (FCCM) program. Specialized care managers will work with the Department of Children & Family Services to develop needs assessments for high-risk children to prioritize care management for those with an autism spectrum disorder, severe emotional disturbance or chronic health conditions.

Identifying Pregnant Members

Recognizing the importance of early identification and management of risk factors in pregnancy, we offer a prenatal program which includes risk assessment (to identify pregnant women at risk for complications), education, high risk pregnancy care management services and obstetrical homecare services for high-risk pregnancies. Pregnant women are connected with a flexible assortment of programs designed to promote knowledge, self-empowerment and healthy choices.

Early identification is the most important factor in the success of a prenatal intervention to impact pregnancy health outcomes. The prenatal program uses a multifaceted approach to identify existing members who become pregnant, including provider notifications; self-referrals enhanced by increased member awareness of the program through communication campaigns and early identification of pregnant members via: claims-based identification; health risk assessments; and state-based referral files (when available). The member will be followed through pregnancy and delivery by our pregnancy program with care management contacts based on risk status.

Mitigating barriers to successfully screening for people potentially eligible for care management

With more than 20 years serving Medicaid members, we have identified challenges to getting members screened and have built our models around a number of best practices to mitigate those risks and lessen their impact as shown in **Figure 8.**

Figure 8

WellCare's Initial Health Risk Screening	
Insight	**WellCare's Informed Approach**
Members prefer engaging with risk screenings in different ways.	WellCare's health risk screening program respects member preferences for communications. Our health risk screening program will feature a variety of administration methods allowing members to choose the approach with which they are most familiar and comfortable – via the web, telephone or in writing.
When calling members, you may not reach them on the first attempt.	WellCare will make three attempts to call members to complete the health risk screening telephonically. Call attempts will be made over the course of different days and different times of the day.
Members identified with special needs upon	Members identified with special needs codes in the enrollment file will be sent directly to care management as a care management referral. A care manager will

WellCare's Initial Health Risk Screening	
Insight	**WellCare's Informed Approach**
enrollment need to be triaged to be assessed for care management quickly.	attempt to contact the member via the telephone to schedule time to complete the screening assessment over the phone or in person. If the care manager is unable to contact the member, WellCare will mail a letter to the member advising the member that we are trying to reach him or her and ask the member to contact us as soon as possible. At the same time, we will outreach to the member's primary care provider of record or other providers, if known, in attempt to identify alternative contact information.
Member engagement may improve when there is an incentive for doing so.	As part of our Healthy Rewards program, members who complete their initial health risk screening within their first 90 days of enrollment will receive a reloadable debit card with a nominal fee loaded to their Healthy Rewards account. This program encourages healthy behaviors and empowers members to take responsibility for their health and health care.
Members may be difficult to contact or unable to be reached.	WellCare will use LexisNexis and Equifax data to identify missing telephone numbers or to update incorrect telephone numbers. In addition, research has demonstrated that community health workers (CHWs) are effective "connectors" to the community because they live in the communities in which they work and understand the social context and barriers that prevent members from accessing care. We have validated the effectiveness of CHWs in other states in which we operate Medicaid health plans. These associates work with schools, state agencies, community centers, and other community-based organizations to locate members. We will explore the ability to replicate this model in Nebraska.

Algorithms and Methodologies for Identifying Members Needing Care Management

All active members are assigned a score, based on a proprietary scoring algorithm that places them into four levels of care management need. In addition to being assigned a score, the members are flagged when specific conditions exist that are likely to be positively impacted by care management. In the first 30 days of a member's enrollment, this score is derived from a combination of initial health risk screening data, pharmacy utilization data and hospital discharge data. After 30-60 days of enrollment, and on a rolling annual basis, the score is refined with any historic medical and pharmacy claims data that has been captured. The scoring of members is based on three primary drivers: clinical severity, utilization, and cost as described below.

- **Clinical severity:** This portion is based on the Chronic Illness and Disability Payment System (CDPS) model, a diagnostic classification system developed by the University of California, San Diego. This Statistical Analysis System model classifies every diagnosis code on a claim and assigns a score based on the severity of the diagnosis. The CDPS model also examines pharmacy utilization as a component of risk scoring.
- **Utilization:** This portion of the model uses a number of utilization indicators and applies a weighted score based on input from the clinical services team. The metrics tracked are hospital admissions, emergency room visits, PCP visits, specialty visits, acute admissions, home health visits, and rehabilitation visits.
- **Cost:** The cost portion scores each member based on his or her relative, normalized PMPM as compared to the other members within the program. The cost component looks at inpatient, outpatient, and professional costs.

In addition to the components mentioned above, algorithms are used to identify specific impactable conditions, such as pregnancy, depression, asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disorder, diabetes, hypertension, AIDS/HIV and children with special needs. The condition-specific model stratifies the results for each member into a clinical risk group based

on diagnosis, procedures, and pharmacy claims information. Those in the higher clinical risk groups are referred to care management for further evaluation.

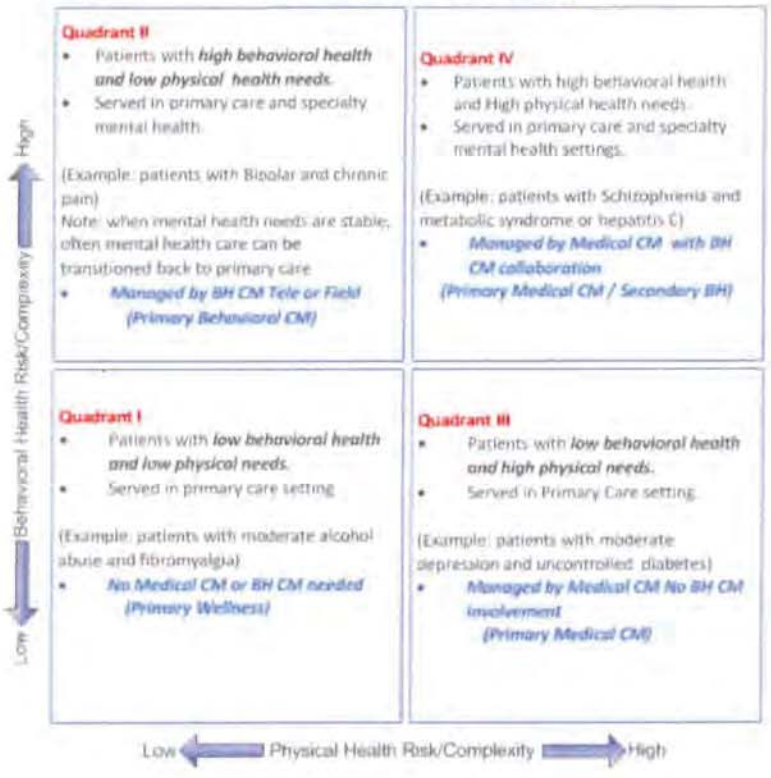
In cases where we don't have claims history, we use the HRS to identify urgent and special health care needs and place members in risk levels. We also supplement the predictive modeling algorithm with the HRS to account for changes that may not be seen in the historical data. Through these various techniques, every member is placed into one of four care management levels, with Risk Level 4 being the most complex and receiving field-based, in-person care management support and Risk Level 1 being the lowest, where a member may need only wellness education and self-management tools.

Another key step in assessing member needs even as they are stratified into risk levels is identifying whether the member has a behavioral health condition that may require a specialized care manager assigned. WellCare includes the following validated screens as part of the comprehensive assessment process and throughout our Care Management Program to identify and assess a member's mental health and substance abuse conditions:

- CAGE/CAGE AID (Drug and alcohol use screening tool for individuals 16+)
- CRAFFT (Screens for high-risk alcohol and other drug disorders for individuals ages 12 to 21)
- PHQ-9 (Depression screening tool for individuals age 13+)
- Edinburgh Postnatal Depression Scale (EPDS)

WellCare uses a four quadrant model (See **Figure 9**) for referral to case management based on the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Four Quadrant model. The following chart represents our model, which connects individuals to care management based on the Member's needs at any point in time in his or her path to recovery and resiliency. The level of care management is assigned based on the results of the comprehensive assessment and the condition currently driving the primary needs of the member.

Figure 9 Four Quadrant Strategy



Engagement of the Member by the Interdisciplinary Care Team

At-risk members with behavioral health needs fall into either Quadrant II or Quadrant IV and receive integrated care management as described below.

- **High Behavioral Health Needs/High Physical Health Needs:** Members in Quadrant IV receive field-based case management. The medical care manager (nurse) is the primary care manager supported by collaboration with the behavioral health case manager.

- **High Behavioral Health Needs/Low Physical Health Needs:** Members in Quadrant II receive either telephonic or field-based case management from an interdisciplinary care team. The behavioral health case manager is the primary and is supported by physical health and community outreach specialists.

Continuous Assessment of Member Need and Risk Levels

Health status is dynamic. Therefore, it is important to have a screening program that accounts for the dynamic nature of health and triggers subsequent screenings and interventions to determine if these changes warrant enrollment in care or disease management or additional coordination for health service needs. There are several circumstances that can trigger the need for reassessment including:

- State provided special needs codes on the 834 enrollment file
- State provided reports
- Hospital admission, which includes a scored discharge tool that identifies a member risk of readmission based on historical utilization of services and current condition and trigger care management interventions based on the results
- Identification of under or over utilization of services: Concurrent and retrospective reviews, claims review and monitoring identify patterns of under-, over-, and inappropriate utilization that may indicate a change in member condition
- PCP/provider request: A PCP/provider may identify a change in a member's condition. When this occurs, the PCP may request that the ICT reassess the member's needs and update the care plan and care plan to reflect additional needs
- Member or caregiver request: periodically a member may identify a concern and ask for updates to their care plan. Such a request would trigger a reassessment and care planning
- Change in members functional, medical, social or behavioral health status
- Community program referrals (No wrong door e.g. AAA, ARC, day care centers)
- Referrals stemming from our Nurse Line, Crisis Line, or Community Assistance Line

Through the Comprehensive Health Risk Assessment (HRA) and reassessments, claim reviews, provider notification, member requests and ongoing monitoring, our care managers will conduct subsequent screenings to ensure that the member's health and safety are established.

WellCare's Proposed Process for Conducting Health Risk Assessments

Once a member is assigned to a care manager, the care manager conducts the comprehensive HRA to develop the member's care plan. To do this, the care manager meets with the member to complete an assessment of the member's medical, behavioral, social economic and psychological needs within 30 days of assignment to care management. Depending on the assigned care management level, the assessment with the care manager may take place in person or via telephone. Based on the information gleaned from the comprehensive assessment, the care manager develops a care plan with the member. In addition to outlining needed services, the care plan is used to identify potential barriers, to clarify or determine realistic goals and objectives and to seek alternative options for the member.

See **Attachment 59_HRA** for a copy of the sample HRA template that WellCare of Nebraska is proposing for our Heritage Health members.

DRAFT WellCare of Nebraska Health Risk Assessment Template

Question Number	Question	Answers
1	What's your ethnicity? Choose one.	□ White, Non-Hispanic □ Black or African-America □ Hispanic □ Asian □ Pacific Islander □ Native American Indian or Native Alaskan □ Native Hawaiian □ Multiracial □ Other
2	Have you ever been diagnosed with any of the following? Choose all that apply.	□ Asthma □ Coronary heart disease □ Diabetes □ High blood pressure □ High cholesterol □ None of the above
3	Have you been experiencing any significant pain for more than 3 months?	□ Yes □ No
4	Select the appropriate answer regarding pregnancy:	□ I'm currently pregnant. □ I had a baby within the last 3 months. □ I'm planning on becoming pregnant in the next 6 months. □ I'm not currently pregnant and not planning on becoming pregnant in the next 6 months.
5	How tall are you (to nearest inch, e.g., 6 ft, 00 in)? Feet? Inches?	_#___ (between 3-7) _##__ (between 0-12)
6	What is your waist measurement (to the nearest inch, measured between the lowest ribs and the top of the hips, not your belt size)?	_##__(between 0-999)
7	How much do you weigh (to the nearest pound)?	_##__(between 0-999)

8	Do you know your blood pressure? (The first number (Systolic) should be between 50 and 300, and the second number (Diastolic) should be between 30 and 180.	□ Yes □ Not the exact numbers, but I've been told it's normal. □ Not the exact numbers, but I've been told it's high. □ No, I don't.
	What is the Systolic number (50-300)?	___ (between 50-300)
	What is the Diastolic number (30-180)?	___ (between 30-180)
9	What was your total cholesterol number? (Please enter a number between 60 and 999.)	___ (between 60-999) □ Don't Know
10	What was your HDL cholesterol number? (Please enter a number between 10 and 150).	___ (between 10-150) □ Don't Know
11	What was your LDL cholesterol? (Please enter a number between 5 and 999.)	___ (between 5-999) □ Don't Know
12	What was your triglyceride number? (Please enter a number between 30 and 999.)	___ (between 30-999) □ Don't Know
13	What was your fasting blood sugar level? (Please enter a number between 30 and 999.)	___ (between 30-999) □ Don't know
14	Would you say that in general your health is:	□ Excellent □ Very Good □ Good □ Fair □ Poor
15	On most days, how many servings of grain products do you eat, such as bread, rice, or pasta? (1 serving of grains = 1 ounce)	□ None □ 1-2 servings □ 3-4 servings □ 5 servings □ 6 servings □ 7 servings □ 8 servings □ 9 servings □ 10 servings □ More than 10 servings

16	On most days, how many cups of fruit do you eat?	□ None □ 1 cup □ 1 1/2 cup □ 2 cups □ 2 1/2 cups □ More than 2 1/2 cups
17	On most days, how many cups of vegetables do you eat?	□ None □ 1 cup □ 1 1/2 cup □ 2 cups □ 2 1/2 cups □ 3 cups □ 3 1/2 cups □ 4 cups □ More than 4 cups
18	Do you ever eat what other people would consider an unusually large amount of food?	□ Yes □ No
19	In a typical week, what is the average amount of time you spend doing moderate-intensity physical activity? (You should be able to have a conversation during these activities but will have an increase in heart rate and breathing and light sweating.) Days per week? Minutes per day?	# (between 0-7) #### (between 0-9999)
20	Do you currently use any of the following tobacco products? Choose all that apply.	□ Cigarettes □ Cigars □ Pipe □ Chewing tobacco □ Snuff □ No, I do not currently use any of these items.
21	In the last month, how often have you felt nervous or stressed?	□ Never □ Rarely □ Sometimes □ Fairly often □ Always

22	How often did you feel depressed during the past week?	□ Rarely or none of the time (less than 1 day) □ Some or little of the time (1-2 days) □ Occasionally or a moderate amount of time (3-4 days) □ Most or all of the time (5-7 days)
23	Over the past week, how much sleep did you generally get in each 24-hour period?	
	Hours?	0-13
	Minutes?	00 or 30
24	On average, how often do you have a drink containing alcohol?	□ Never. I do not drink. □ Less than once a month □ Once a month □ 2-3 days a month □ 1-2 days a week □ 3-4 days a week □ Nearly every day
25	How many drinks containing alcohol do you have on a typical day when you are drinking?	## (between 0-50)
26	How often do you use a seatbelt when you drive or ride in a car?	□ Never □ Seldom □ Sometimes □ Nearly always □ Always □ I never drive or ride in a car.
27	During the past 12 months, how many times have you driven a car or other motor vehicle within 2 hours after drinking an alcoholic beverage?	## (between 0-99)
28	When you go outside on a very sunny day for more than 15 minutes, which of the following do you always do? Choose all that apply.	□ Wear protective clothing such as wide-brimmed hats or long sleeve shirts □ Avoid the sun by staying in the shade □ Use sunscreen of SPF 15 or higher

29	During the past 4 weeks, how much did your health problems affect your productivity while you were working? Think about the days you were limited in the amount of kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your activities a great deal. 0 = Health problems had no effect on my work, 10 = Health problems completely prevented me from working	## (between 0-10)
30	Based on what you shared with us, your health could use some improvement in the following area(s). Which area would you like to work on?	□ Weight management □ Nutrition □ Physical activity □ Stress management □ Alcohol □ Tobacco □ Skin Protection □ Injury prevention □ Depressive symptoms
31	How motivated are you to work on your: (0 = Not at all motivated, 10 = Extremely motivated	
	Weight management	## (between 0-10)
	Physical activity	## (between 0-10)
	Nutrition	## (between 0-10)
	Stress management	## (between 0-10)
	Alcohol use	## (between 0-10)
	Smoking	## (between 0-10)
	Skin protection	## (between 0-10)
	Injury prevention	## (between 0-10)
32	Slightly different question, how confident are you that you can improve your: (0 = Not at all confident, 10 = Extremely confident)	
	Weight management	## (between 0-10)
	Physical activity	## (between 0-10)
	Nutrition	## (between 0-10)

	Stress management	## (between 0-10)
	Alcohol use	## (between 0-10)
	Smoking	## (between 0-10)
	Skin protection	## (between 0-10)
	Injury prevention	## (between 0-10)
33	Do you need any help with hearing?	□ Yes, I need assistance with hearing. □ No, I do not need assistance. If yes, why: □ Deaf □ Hard of Hearing/Permanent Hearing Loss (in one or both ears) □ Tinnitus □ Temporary Hearing Loss (sinus infection or other temporary condition) □ Other (Specify)
34	Do you need any help with seeing? (Please mark yes only if you still have trouble seeing when wearing glasses or contacts)	□ Yes, I need assistance with seeing □ No, I do not need assistance
35	What is your preferred language?	□ English □ Spanish □ Russian □ Chinese □ Bengali □ Urdu □ Creole □ Ilocano □ Korean □ Vietnamese □ Mexican-Spanish □ Other
36	When was your last mammogram?	□ Less than 1 year ago □ 1 to 2 years ago □ More than 2 years ago □ Don't know □ I've never had a mammogram
37	When was your last Pap smear?	□ Less than 1 year ago □ 1 to 3 years ago □ More than 3 years ago □ Don't know □ I've never had a Pap smear.

38	Have you had a colonoscopy within the last 10 years? (This is when a tube is inserted in the rectum to check the large intestine for colon cancer.)	□ Yes □ No □ Don't know
39	Have you had in influenza (flu) vaccine within the last 12 months?	□ Yes □ No □ Don't know
40	Which of the following conditions have you been treated for?	□ Alcohol abuse
		□ Allergies
		□ Alzheimer's / Dementia
		□ Amputation of a leg, foot or toe
		□ Angina
		□ Anxiety
		□ Atrial fibrillation or an Irregular heart rate/rhythm
		□ Asthma
		□ Back pain
		□ Blind/Impaired vision that cannot be corrected
		□ Blood disorders/Anemia
		□ Bipolar disorder
		□ Cancer - Type/Where
		□ Chest pain/Heart Condition
		□ Chronic kidney disease
		□ Chronic fatigue syndrome
		□ Chronic obstructive pulmonary disease (COPD, including chronic bronchitis and emphysema)
		□ Chronic pain
		□ Coronary heart disease
		□ Depression
		□ Diabetes
		□ Eating Disorder (Anorexia, Bulimia)
		□ Fibromyalgia
		□ Gastro esophageal reflux disease (GERD)
		□ Heart attack
		□ Heart failure/Congestive Heart Failure (CHF)
		□ Hepatitis Disease
		□ High blood pressure
		□ High cholesterol
		□ HIV/AIDs

		□ Insomnia
		□ Irritable bowel syndrome
		□ Liver Disease
		□ Migraine
		□ Neuropathy / Loss of Sensation or tingling in feet or hands
		□ None of the above
		□ Obesity
		□ Open Wound that is not healing properly
		□ Organ Transplant
		□ Osteoarthritis
		□ Osteoporosis
		□ Other
		□ PDD also known as Asperger's or autism
		□ Peripheral vascular disease (PVD)
		□ Rheumatoid arthritis
		□ Schizophrenia
		□ Sickle Cell Disease
		□ Stroke or transient ischemic attack (TIA)
		□ Substance abuse
41	Telephonic: May we continue to use this phone number or is there a better number to contact you? Portal/Paper: What is the best phone number to contact you?	□ Yes □ No □ Specify Other number:
42	Are there any cultural or religious beliefs that affect your healthcare?	□ Yes □ No Please explain:
43	What is your marital status?	□ Married □ Divorced □ Separated □ Never Married □ Widowed □ Other (specify)
44	What is your date of birth?	MM/DD/YYYY
45	What is your gender?	□ Female □ Male

46	What is your highest level of education?	□ N/A based on child's age □ Still attending school □ Less than high school graduate □ High School graduate/G.E.D. □ Some college or Associate's Degree □ College graduate □ Graduate Degree
47	What is your current employment status?	□ Full-Time □ Part-Time □ Volunteer Service Hours □ None
48	Which of the following best describes your living situation?	□ Home/Condo/Apt. you own □ Home/Condo/Apt. you rent □ Assisted Living Facility □ Retirement Community □ Senior Housing Nursing Home □ Homeless □ Friend or Relative's home □ Other (Specify):
49	With whom do you live? (Check all that apply)	□ Alone □ Spouse/Significant Other □ Child(ren) □ Grandchild(ren) Parent Sibling □ Other Family Member □ Roommate/Friend □ Other (relationship):
50	Do you have someone such as a family member, friend, paid caregiver or community support program to help you if you become ill?	□ Yes □ No
51	Do you have a primary care doctor?	□ Yes □ No

52	Have you scheduled a visit with your Primary Care Provider (PCP)?	□ Yes □ No
53	Telephonic: If no; Do you need assistance scheduling a visit with your PCP? Portal/Paper: Call phone number on back of ID card for assistance with scheduling an appointment to see your PCP.	
54	Do you have regular and reliable transportation to get to doctor's appointments or clinic visits?	□ Yes □ No
55	Are you receiving any services for physical, occupational, speech therapy, or long term support services?	Select all that apply: □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Long Term Support Services □ None
56	Do you have difficulty understanding or remembering new information?	□ Yes □ No
57	Are you receiving hospice services?	□ Yes □ No
58	In the past week have you experienced any	□ Lower body muscle weakness or generalized fatigue? □ Pain in your back that affects your mobility or daily activities? □ Loss of balance or unsteadiness when you walk or get up from a chair or bed? □ Dizziness or vertigo when you walk or get up from a chair or bed? □ Forgetfulness, memory loss or confusion?
59	How many prescription medications do you take per day?	□ None □ 1-3 □ 4-6 □ 7-10 □ More than 10 □ Unsure
59	How many non-prescription or over the counter medications do you take per day?	□ None □ 1-3 □ 4-6 □ 7-10 □ More than 10 □ Unsure

60	What are your current medications?	Free text box
61	In the past 6 months, how many times have you stayed overnight in the hospital?	□ 1 □ 2 □ 3 □ 4 or more
62	In the past 6 months, how many times have you visited the emergency room?	□ 1 □ 2 □ 3 □ 4 or more
63	In the past 6 month, how many times have you had surgery?	□ 1 □ 2 □ 3 □ 4 or more
64	In the past month, have you had frequent shortness of breath, chest pain, and/or had swelling of the ankles or feet before getting out of bed in the morning?	Check all that apply - □ Shortness of Breath □ Chest Pain □ Swelling □ None
65	How many times in the past 6 months have you had an episode of fainting, falling or dropping to the ground or lost your balance, slipped or tripped over something that resulted in falling or dropping to the ground?	XX Times
65	Do you have difficulty doing any of the following without help from another person?	□ Taking your medications □ Using the telephone □ Managing your finances □ Doing your housework □ Doing your laundry □ Shopping for groceries □ Transporting yourself/Transportation □ Preparing your meals □ Getting in and out of bed or chair □ Dressing and undressing yourself □ Bathing yourself □ Feeding yourself □ Getting or off the toilet

66	Can you afford the food you need?	□ Yes □ No
67	Do you currently use any of the following medical equipment or devices? Select all that apply or choose none	□ Electric Chair Lift □ Electric Stair Lift □ Electric Cart or Scooter □ Raised Toilet Seat □ Toilet Safety Frame/grab bar □ Bedside Commode □ Urinary Catheter □ Oxygen Equipment □ Grab Bars in Tub or Shower □ Hospital Bed □ Wheelchair □ Walker □ Cane □ Crutches □ Prosthesis/Leg Braces □ Other; Specify □ None
68	Over the last two weeks have you been bothered by:	□ Little interest or pleasure in doing things □ Feeling down, depressed or hopeless □ Are you receiving counseling for depression
69	If you are a new member with WellCare, were you enrolled in Case or Disease Management with your previous healthcare insurance?	□ Yes, Case Management (if yes trigger referral to CM) □ Yes, Disease Management (if yes trigger referral to DM) □ No □ I don't know □ Not applicable
70	Would you be interested in receiving Case Management Services?	□ Yes □ No

SECTION IV.L CARE MANAGEMENT

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

WELLCARE'S RISK LEVELS AND SERVICES AT EACH LEVEL: A TAILORED APPROACH

WellCare's risk levels (**Figure 10**) range from one to four with Level 4 signifying the most highly complex patients and Level 1 signifying the lowest need level. WellCare acknowledges that our use of these risk levels must be reviewed and approved by MLTC.

Figure 10

WELLCARE'S CARE COORDINATION PROGRAM	
Risk Stratification Levels	**Stratification Level Description**
Care management Level 4	This level will be for our highest risk and most complex members. These members have catastrophic, high-risk, high-cost needs, and require special assistance negotiating health and social services systems. Level 4 members will include those with intensive special health care needs, complex discharge needs, high risk pregnancy, multiple emergency room visits or frequent hospitalizations or readmissions, catastrophic conditions, and members who are medically fragile including those LTSS members in the community, nursing facility, and ICF/ID. Members stratified as Level 4 will require the highest level of care management intensity.
Care management Level 3	This level denotes our moderately high risk or complex members. They may include, without limitation, children with special health care needs, members with chronic conditions, members with frequent emergency room visits or hospitalizations. Members, who may have a combination of medical, social, and mental health needs, will be assigned a primary care manager who is supported by an interdisciplinary team.
Care management Level 2	This level denotes members with moderately acute and complex needs. These members may require disease management for conditions including but not limited to asthma, controlled diabetes, and hypertension.
Care management Level 1	This level denotes our lowest risk member. They are stable and have only a few interventions on their care plan. They will require only periodic support and monitoring.

WellCare's care management program design contemplates differences between members and member needs over time. It's intensely individualized because we do not believe in a one-size-fits all set of services and care planning for members in our care management program. For instance, a member may be "Level 4" in terms of their risk level, but in reality we may find that they are actually in an effective care management program through agencies like the Area Agencies on Aging or Wraparound/Coordinated System of Care type coordination through the Regional Behavioral Health Authorities. To avoid duplication of efforts, those members will receive different care management supports than those who are wholly unmanaged.

Our program matches the intensity of services we provide to our members' clinical profiles and health needs, which vary member to member and, for a given member, varies over time as shown in **Figure 11**. This level of stratification corresponds to the type and intensity of care management services (i.e., face to face, telephonic or educational material mailings,) offered to help members manage chronic or acute conditions. This stratification allows WellCare to deploy critical care management resources to where member needs and opportunities to impact health outcomes are greatest.

A key component of the services our members with the most complex needs receive is in-home support.

We have found that nothing replaces a nurse or licensed behavioral health professional being in the home, meeting with members face-to-face and with their families and caregivers. We will hire care managers from within the communities in which our members live and they will remain in those communities so those irreplaceable in-home contacts can be made.

Figure 11

WellCare's Care Coordination Program	
Risk Levels	**Description of Services Provided at Each Level**
Care management Level 4	Each Level 4 member will be assigned a care manager who is a registered nurse, licensed clinical social worker, or mental health specialist depending on the member's most significant needs. ***Care management will be in-person/face to face and supplemented with telephonic outreach throughout the members' time in Level 4.*** Care managers will assess their health and develop a care plan aimed at stabilizing the member. The care manager will contact the member frequently, at least once a week, and actively assists with transition of care, appointments, referrals, transportation, forms, paperwork, and marshaling various health and social service providers.
Care management Level 3	Each Level 3 member will be assigned a care manager who is a registered nurse, licensed clinical social worker, or mental health specialist depending on the member's most significant needs. Members, who may have a combination of medical, social, and mental health needs, will be assigned a primary care manager who is supported by an interdisciplinary team. Care managers will assess their health and develop a care plan aimed at reducing risk level. Care management will be primarily telephonic but face to face interactions may occur. The care manager will contact the member and assist with referrals, transportation, and community-based services.
Care management Level 2	Each of these members is assigned to a primary disease manager or health coach who will provide telephonic outreach and personalized education and link members to community-based programs (i.e., such as smoking cessation). Health coaches are appropriately trained for the scope of their roles and have clinical registered nurse oversight for issues escalation if a member has an acute health need that needs to be addressed. Some health coaches have specialized training as diabetes educators, exercise physiologists or nutritionists. Disease management outreach will be telephonic. Disease managers will assess their health and develop a care plan aimed at maintaining or reducing risk level. Their care manager will assists with referrals, transportation, and community-based services.
Care management Level 1	Outreach will be telephonic for any Level 1 Member referred to Care or Disease management. Care managers will assess their health and develop a care plan in concert with the member, his or her providers, and care givers. The care manager will ensure that the member has information about public assistance programs for health and social services which would benefit them and to which they may be entitled. The care manager will contact them at least once a month to assess their status and progress against goals. The care manager will update the member's care plan monthly or as their health status or circumstances change. Level 1 Members who are not referred to Care Management will receive educational literature mailings.

Tailoring Care Management to Meet Member Needs Based on Specific Conditions

Within each care management level, services offered will flex based on special health conditions of individual or groups of members. For instance, members identified with high-risk pregnancies will receive services through our high-risk OB program which includes additional education and outreach, as well as access to our Healthy Rewards programs. Members in foster care will receive additional

interdisciplinary support through our Foster Care Care Management program, and members with transplant needs will receive support through our Catastrophic Case Rounds effort that focuses on effective discharge planning for members with very complex and chronic needs.

WellCare's Pregnancy and High-Risk OB Program

The WellCare Pregnancy Program provides education, guidance and support for all WellCare pregnant members. The intent of the program is to provide helpful tips, tools and information for pregnant members to make healthy choices during pregnancy to achieve the healthiest birth outcome possible.

The program identifies pregnant members through state files, claims and member or provider direct notification. Upon recognition of the pregnancy, an outreach call is placed to all pregnant members to assess the current health status, risk stratify the member based on future risk for preterm birth or pregnancy complications. Pregnancy assessments of the member will be conducted as early in the pregnancy as notification is received, mid-point of pregnancy and finally, upon delivery. The risk assessment touches seek to identify pregnant members facing current or prospective risks in their condition for engagement in the High Risk Obstetrics Program. The High Risk Obstetrics Program assigns a specially trained Obstetrical Registered Nurse to follow the member closely for education and support to navigate their high risk pregnancy journey. These members will be supported through plan and community resources to adhere to the high risk pregnancy plan of care to achieve best birth outcome possible for the member.

All WellCare Pregnancy Program members are offered the following to support their pregnancy journey:

- Assessments throughout pregnancy to assess for high risk factors
- Complimentary book on pregnancy and newborn care
- Infant Immunization Chart (Published by Centers for Disease Control)
- 24/7 Pregnancy Nurse Support line
- WellCare Pregnancy website
- Text 4 Babies (https://www.text4baby.org/)
- Incentives to complete prenatal and postnatal care

Field-based Care Management

Members in the highest risk levels (Level 4 or Level 3 with four or more impactable co-morbid conditions) are provided field-based in-home care management services. The Field-Based Short Term Case Management (SCM) Team consists of registered nurses, social workers and care coordinators. Members receive personal care with home visits, a care plan developed and monitored by an Interdisciplinary Care Team (ICT), assistance navigating the array of benefits and services available to them, direct contact to their assigned care manager, support and education for their caregiver and access to our community outreach associates to help connect to social services resources.

Disease Management for Lower Risk Level Members

The WellCare Disease Management Program is designed to be complimentary and supportive to members in the lower risk levels. A member may be referred directly to the Disease Management Program or referred upon completion of higher levels of care management. The Disease Management Program staff has full view of the member's assessments, case notes and health care claims to deliver education, guidance and support for the primary chronic condition for which a member may need additional support.

The six key chronic conditions that are addressed in the Disease Management Program are:

- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease

- Congestive Heart Failure
- Diabetes
- Hypertension

Members in the Disease Management Program members are offered supportive disease specific educational materials from our Vendor Partner, Krames, written in easy to understand language for better management of their condition. Upon completion of the Disease Management Program, the member is offered supplemental condition specific mailings twice a year via mail as long as desired.

INNOVATIVE CARE MANAGEMENT STRATEGIES MLTC MAY WANT TO CONSIDER

Implementing Special Needs Codes

Given our experience with the Agency for Health Care Administration (AHCA) in Florida, we suggest that MLTC expand the use of "special codes" to include indicators such as children with special needs, HCBS waiver populations and specific impactable chronic physical (i.e. sickle cell) and behavioral health (i.e. schizophrenia) conditions. Providing this information at the time of enrollment would facilitate transition of care and assist case management staff to prioritize Health Risk Assessments (HRAs) and care manager assignment.

Focused Cross-agency Support for Foster Care Members and Smooth Transitions of Care

Foster Care members will automatically be eligible for WellCare's specialized Foster Care Care Management program, and they will receive different levels of support and coordination depending on their needs assessments. Based on our extensive and successful experience working with this population in Kentucky, we encourage partnerships between WellCare, MLTC, the Division of Children and Family Services, providers, family advocates and the judicial system to ensure a streamlined effort to assess needs and ensure the right levels of care coordination for individualized foster children.

We know that by the time foster children reach us, they often have an array of care plans and assessments. We would encourage initiatives to streamline the sharing of the young person's history to ensure the best and most appropriate care coordination.

For instance, WellCare affiliates in New York and New Jersey established FTP sites to receive assessments for certain members from their Departments of Public Health. The assessment and associated data are automatically loaded into WellCare's Medical Management Platform (MMP) and processed through an intake review and linked to the Member record. Where assessment information indicates the need for care management, a care manager is assigned and the care management process immediately begins, with the assessment information being directly integrated into our plan of care.

SECTION IV.L CARE MANAGEMENT

61. Describe how the MCO will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover. *(Page limit 2 pages)*

HEALTH*CONNECTIONS*: ASSISTING MEMBERS TO GAIN ACCESS TO COMMUNITY RESOURCES

WellCare recognizes that helping our members achieve improved health outcomes and enhanced quality of life requires us helping them to navigate "the 80 percent of healthcare that doesn't happen in a doctor's office." Having exclusively served members in government-sponsored health care programs for more than 20 years, we know first-hand the unique barriers our members face – from food insecurity to unstable housing and a host of other social determinants that undermine our members' ability to optimize their health outcomes. ***In response, WellCare created the proprietary HealthConnections Model to support our members in accessing and using social services to reduce those barriers and to find locally based community health and wellness programs.***

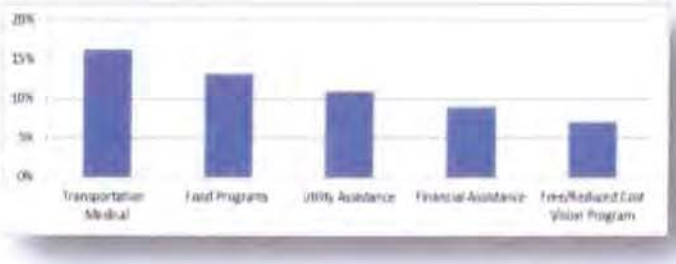
Best-in-Class: Social Services Support
With a social service network of 110,000 organizations, WellCare has referred 8,394 consumers to 6,899 organizations to access 26,614 social services.

At the core of Health*Connections* is the concept that the social service network is a vital component of the healthcare delivery system. With this in mind, WellCare uses traditional public health methods to research and catalogue available community-based programs, activities and services that comprise the social safety net. WellCare CommUnity Liaisons load the network into a centralized CommUnity Command Center that is accessed by member-facing and community-facing representatives who can search for available services and record the referral in a social service electronic health record (SSEHR). This SSEHR maintains information for each caller on all referrals and their disposition. This transactional-level tracking provides tremendous micro- and macro-level data for social service related analysis. ***To date, we have loaded more than 5,000 services into the Nebraska-specific database, which doesn't yet include services loaded from border states, which we know can also benefit Heritage Health members.***

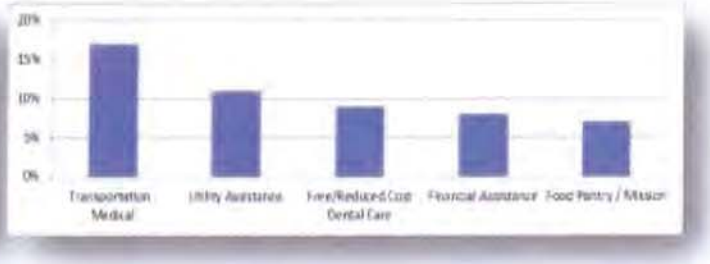
WellCare launched the Health*Connections* model in Kentucky in November 2011. Now operating in 12 states, WellCare has referred nearly 8,400 people to more than 26,000 social services offered through nearly 6,900 organizations. In addition, during this same period, WellCare identified and closed nearly 1,600 social service gaps. The top five referral categories and gaps are identified in **Figure 12**.

Figure 12

Top Five Referrals by Category



Top Five Gaps by Category



The important role of the social safety net provider in the healthcare continuum for individuals enrolled in Medicaid heavily influences how we can engage with our communities. Connecting members to social services represents one piece to the equation. The primary goal of the Health*Connections* Model is to improve the health and vitality of our members and communities by supporting the social safety net and quantifying its impact on health outcomes. WellCare has identified four complementary program elements to help achieve this goal shown in **Figure 13**.

Figure 13

- ***CommUnity Activities*** – Community based health and wellness events leveraging existing programs.
- ***HealthConnections Councils*** – Community planning councils focused on quantifying the breadth and scope of the available social safety net and identifying creative and innovative ways to help support the network together with other community and civic leaders.
- ***Social Service Utilization Support*** – Facilitating member connections to social services and bridging gaps in available community-based programs and services. WellCare care managers, CommUnity Advocates, member services representatives and other associates are trained on accessing our social services database and CommUnity Assistance Line to directly help members in need of specialized social service support.
- ***CommUnity Health Investment Program*** – Strategic philanthropic granting program to support community-based innovation and to pilot potential social service payment models. Our investment program is highly targeted based on very specific data related to our members. We enter into formal business agreements with our partners, which allows us to track services and tie access to social services back to improved health outcomes and enhanced quality of life for our members.

WellCare of Nebraska uses a data-driven process (called the Health*Connections* CommUnity Development Approach) to identify health topics that impact the communities we serve. Using this information, WellCare CommUnity Advocates prepare an action plan and assemble an internal cross functional team to review the data and the proposed plan. Then, with the team's guidance, the CommUnity Advocate implements a community health initiative that engages with public health stakeholders. One consistent topic in all markets is access to healthy foods, and WellCare developed a program that it proposes in all markets including Nebraska.

In Illinois, for example, the local CommUnity Advocacy team partnered with a community-based non-profit and the local farmer's market association to offer a double coupon program for low-income families accessing Supplemental Nutrition Assistance Program (SNAP) benefits when they used their benefit at a local farmers market to buy healthy food options like fruits and vegetables. Called LinkUP Illinois, more than 40 farmer's market now participate with benefits for both the SNAP recipients and to the farmer's market vendors. According to Experimental Station, every $1 of SNAP money spent creates $1.73 for local economies. In total, the program generated nearly $215,000 in increased sales of locally grown, farm fresh foods with fruits and vegetables representing more than half of the total purchases.

SECTION IV.L CARE MANAGEMENT

62. Describe the MCO's strategy to address the unique challenges when coordinating care for dual-eligible individuals who receive their services from both Medicare and Medicaid. *(Page limit 2 pages)*

COLLABORATION AND PARTNERSHIP: THE WELLCARE STRATEGY FOR COORDINATING CARE FOR DUAL-ELIGIBLES

WellCare serves 2.4 million Medicaid members and more than 350,000 Medicare Advantage members across 16 states, so the unique challenge of serving dually-eligible individuals has become a regular part of doing business for us. Among our members are those in the Dual Special Needs Populations, Fully Integrated Dual Advantage (FIDA) Aged, Blind and Disabled (ABD), Foster Children, Adults with Serious Mental Illness and Children with Serious Emotional Disturbances, individuals with Developmental Disabilities and those receiving Home and Community-Based Waiver Services (HCBS) and Long Term Supports and Services (LTSS). Because of the broad range of entities that provide coverage and services to these diverse populations, we have developed informal and formal processes for coordinating care across different payers and care coordination entities. And because we have Medicare Advantage programs as well as Medicaid programs, we have developed these processes based on best practices from both sides to ensure a seamless process for members.

Our goal when working with dually eligible members is to avoid duplication of care coordination services and present a single coordination strategy regardless of who is responsible for the service. Under this model, members with co-morbid and complex conditions receiving most of their physical health, pharmacy and basic behavioral services through their Medicare Advantage plan or through fee-for-service Medicare, but receiving specialty behavioral health or community-based care through a WellCare Medicaid plan, should see only a single care coordination process that is focused on their primary needs and acuities. WellCare will collaborate and partner with any other Care Managers in the member's Interdisciplinary Care Team to ensure timely, unduplicated coordination of services.

WellCare recognizes that for our Heritage Health members, we are responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. We also understand that we must ensure that services are provided without charge to members who are dually eligible for Medicare and Medicaid, and that we must coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. We also recognize that not all Medicare members in Nebraska are part of a Medicare Advantage plan, so there is opportunity for increased access to coordinated care for dually eligible members.

Our strategy for facilitating care coordination for dual eligible individuals is multi-faceted:

Step 1: Identification. Using Coordination of Benefits information, our care management platform provides a fully integrated and 360-degree view of a member's coverage and benefits so when a request comes in for a member, our affiliates can quickly identify if the member is Medicare and can identify if they have a Medicare Advantage Plan.

Step 2: Assessment of Need. We seek to fully understand a member's care coordination needs either through screening or a formal Health Risk Assessment. Members enrolled in the Case Management program will complete a comprehensive assessment that will also provide insight into member coordination and educational needs. To avoid repeated requests for medical history or diagnostic tests, we seek to coordinate with the Medicare plans or providers to access this information if an assessment has already been done.

Step 3: Inventory of Benefits and Resources. Our systems clearly outline benefits and services available to members through WellCare, and our care managers are trained on WellCare benefits. Any

benefits outside WellCare may be coordinated through other payers or community based resources. When our members require a benefit that WellCare does not provide, our care managers help navigate the member to the appropriate source, including social services. We know that most of our dual-eligible members have many needs outside of physical and behavioral health care to sustain their overall health and quality of life. For that reason, we ensure our care coordination plans include our Health*Connections* efforts to connect members to needed social services available in their communities. We also know that some of our dually eligible members will be residing in a nursing facility or intermediate care facility. Based on Nebraska's regulations for services covered by the facility payment, we will coordinate with the facility to ensure members have access to services identified through care planning and assessment.

Step 4: Sharing of Data and Information. Across both our Medicaid and Medicare plans, we share member information in accordance with all state and federal privacy rules when requested. This information can include hospital admissions or discharge plans or other plans of care that partner plans can use to help facilitate smooth transitions and follow-ups. In other states we have set up FTP transmission for secure information transfer between plans, as well as with nursing homes and waiver service coordinators at local Area Agencies on Aging as needed, to ensure critical patient information is available to all appropriate parties in a timely manner. In Nebraska, we have already been meeting with the Nebraska Health Information Initiative (NeHII) which we could use to help us even more effectively exchange patient information to ensure seamless care regardless of primary payer or provider.

Step 5: Collaboration among Plans and Providers. Successful care coordination among diverse entities serving our members is built on front-line relationships and team-based care. Nurses and social workers form direct connections with their counterparts in other plans. This helps reduce duplication of services and helps the plan optimize its ability to help the member based on their primary diagnoses and provider needs. For instance, a dually-eligible individual with SMI receiving Assertive Community Treatment (ACT) services, which are only covered by Medicaid, is best served having their care coordination guided by the Medicaid plan rather than the Medicare plan that would not have a relationship with the ACT provider and would be more disconnected from the member's day in and day out care needs. However, a member in a nursing facility with complex physical needs being managed by their Medicare plan would be better served having care coordination guided by their Medicare plan which has the relationship with the facility. In these cases, when one plan or the other can clearly become the member's care coordination home, it is incumbent on the primary plan to keep the other parties informed of critical changes or barriers. Our experience has taught us that peer-to-peer discussion of complex cases is critical to ensuring a dual-eligible member receives high quality coordinated care. In Tennessee, for example, WellCare's Medicare Advantage plan has established monthly meetings between the Medicaid plans and the Dual Special Needs Plans to discuss member case issues. For members in Medicare fee-for-service, our Care Managers would directly engage the member's providers and others in the Interdisciplinary Care Team to discuss and collaborate on a care plan.

Additionally, our systems are built to provide streamlined processes for providers working between plans including promoting data sharing agreements that allow us to cross over claims seamlessly and fraud, waste and abuse and Coordination of Benefits protocols to ensure Medicaid remains the payer of last resort and providers aren't double billing.

Leveraging Providers to further Enhance Coordination Efforts

In addition to direct coordination between care managers from different plans, WellCare recognizes that many providers in Nebraska have taken ever-increasing responsibility for care coordination through their efforts as Patient-Centered Medical Homes (PCMH). Our plan to help support and enhance the PCMH model includes recognition of the role PCMHs can play in navigating between members' Medicare and Medicaid plans.

SECTION IV.L CARE MANAGEMENT

63. Describe the process for care coordination for members who are Tribal members or are otherwise eligible for care through Indian Health Services. *(Page limit 1 page)*

SUPPORTING TRIBAL MEMBERS: WELLCARE'S PROCESS FOR SPECIALIZED CARE COORDINATION

WellCare is adept at tailoring our care management model to meet specific and unique needs of diverse populations. Through connections with the Nebraska Urban Indian Health Coalition, we had the opportunity to meet with representatives from clinics from the Omaha, Santee Sioux, Ponca and Winnebago tribes. We also met with ABD and dually-eligible tribal members in focus groups. Recognizing that our Native American members have very specific and protected rights and 638 tribal clinics/Indian Health Services fall under strong federal guidelines, we have built our Tribal Care Management strategy to strengthen and supplement existing programs. This strategy, based on those meetings with members and providers, includes the following priorities:

- **Development of specific policies and procedures for working with Tribal Clinics:** These policies will highlight the importance of supplementing rather than duplicating the efforts of the Tribal Clinics and coordinating care for our shared members. Two ways we will support the clinics is through data sharing and the use of our CommUnity Assistance Line for referrals to social services.
- **Integrating the Tribal Network Liaison into our functional structure**: The liaison will report through provider services, but will work closely with clinical and quality staff members on behalf of Native American members through our already integrated operational structure.
- **Developing specific expertise among our field-based care managers:** We will look for opportunities to supplement our care management team with qualified Native Americans, and we will build specific training across all of our field-based care managers related to working with the 638 tribal clinics and Indian Health Services. We will make sure that all of our care management processes are sensitive to the culture, value and beliefs of the tribal community in relation to their engagement and acceptance of our assistance. We understand that inclusion of family members and other support systems are essential to the process.
- **Connecting Community Advocates with the Tribal Clinics to supplement Wellness activities:** We were very impressed with the many activities the tribes are undertaking to improve wellness of their patients and we would like to support those programs. The Omaha's efforts, for example, to develop a robust nutrition education for patients with diabetes (including a full kitchen to train on healthy cooking) is perfectly aligned to programs we are executing across the country through our award-winning Health*Connections* model.
- **Supporting existing and emerging capacity Integration within the Tribal Clinics**: The tribal clinics in Nebraska are advanced among many primary care provider groups in terms of co-locating and integrating behavioral health into their practices. This is an effort WellCare would like to build upon. For example, we can expand on the effort by the Santee Sioux to provide telepsychiatry services for their patients.
- **Ensuring Tribal Representation on key Committees**: Key to our strategy to ensuring our tribal members are getting what they need and that our Tribal Care Management program is effective is making sure we have a way to get structured and consistent feedback from the tribal clinics. To help in that effort, WellCare will commit to ensuring regular tribal representation on key committees such as the Clinical Advisory Committee, Member Advisory Committee or Provider Advisory Committee.

SECTION IV.L CARE MANAGEMENT

64. Describe how the MCO will coordinate service planning, service delivery, and post-discharge care among discharge planners (including State psychiatric hospitals) and home health and other service providers. Include the MCO's approach to care management for youth discharged from residential care. Explain how the MCO will monitor the post-discharge care of members who receive services in remote areas. *(Page limit 4 pages)*

SETTING MEMBERS UP FOR SUCCESS: COORDINATION OF SERVICE PLANNING, SERVICE DELIVERY AND POST-DISCHARGE CARE

WellCare embraces a fully integrated proactive approach to discharge planning that empowers members and caregivers to take charge of their own wellness and recovery. Our discharge planning processes focus on providing the full continuum of supports needed to reduce unnecessary readmissions to the hospital or trips to the emergency room.

To ensure optimal transition for a member following discharge from an institutional setting, we conduct an evaluation of the member's medical, behavioral health and social needs during an initial screening conducted within 24 hours of notification of a member's admission. Based on this assessment, we identify services, supplies and community resources needed to facilitate a seamless and safe discharge transition.

Discharge planning is a collaborative and cooperative effort between the member, the attending physician, facility discharge planner, and WellCare's concurrent review nurse and/or licensed behavioral health professional, ancillary providers and community resources. The services provided through our comprehensive discharge plan may include:

- Link to their primary care provider (PCP) and specific specialists
- Durable medical equipment
- Transfers to an appropriate step-down facility (i.e., skilled nursing facility)
- Home health care
- Medication management
- Physical, occupational or speech therapy
- Social and community-based services
- Outpatient Behavioral health services

WellCare trains dedicated associates on the process of discharge planning and assigns them to a Transition Care Coordinator Team to ensure focus on effective discharge planning and follow-up. Transition Care Coordinators work under WellCare's five fundamental principles (See **Figure 14**) of effective discharge planning: access, integration, person-centeredness, teamwork and data-informed coordination.

Figure 14

THE FOUNDATIONS OF WELLCARE'S DISCHARGE PLANNING PROCESSES	
Access	One of the most consistent predictors of success post-discharge is access to quality community-based services. Whether that's rehabilitation services for a stroke victim, in-home care for a transplant patient, or an array of outpatient and home-based services for individuals with Serious Mental Illness (SMI), WellCare takes seriously our responsibility to ensure members have access to the services and providers they need to be successful in their own personal recovery. We know that currently in Nebraska, natural patterns of care often drive people back to urban centers including those in border states, for follow-up, which can present unique transportation and other access challenges. To help combat these challenges, our discharge planning process includes a full review of geographic barriers the member and caregiver may face, an inventory of available healthcare and community resources and the deployment of a Remote Access Discharge Plan that could use a combination of consultative services, telehealth and telemonitoring, as well as our field-based case management services built within communities across the state.

The Foundations of WellCare's Discharge Planning Processes	
Integration	WellCare offers fully integrated programs and services, so discharge planning naturally is done as an integrated plan considering the member's behavioral, physical and psychosocial needs. Discharge planning nurses and social workers work together along with our CommUnity Advocates to identify needs within the healthcare continuum for the member post discharge as well as social needs that could range from access to housing or home modification resources to supported employment resources for members exiting a state psychiatric hospital or other long-term facility.
Person-Centeredness	A critical part of effective discharge planning is ensuring members and caregivers are fully engaged in the plan. The principles of recovery-focused care planning seen in behavioral health care apply equally to physical health care needs, and our integrated approach helps ensure person-centered planning regardless of member condition. Our Transition Coordinators facilitate person-centered planning by partnering with facility discharge planners to engage members to discuss the plan throughout the concurrent review process. Having member sign-off and engagement is written into our discharge processes. And for members with high acuity needs who may need Catastrophic Case Rounds, such as transplant patients and SMI patients exiting long-term care, we will deploy field-based case managers or peers, as appropriate, to work directly with patients.
Teamwork	Discharge planning is a core responsibility of every contracted facility in our network but it's not one we expect them to do in a silo. Our Transition Care Coordination associates within our Utilization Management team partner with facilities, PCPs, specialists, caregivers, members, social workers, community resources and state agencies as appropriate to develop interdisciplinary care teams to ensure a member's discharge considers all the potential barriers to success and engages all resources to mitigate those barriers. One successful strategy we have used in other states to incent providers to conduct effective discharge planning is our "Gold Card" program. "Gold Card" hospitals are designated based on their outcomes particularly around follow-up after hospitalization, average length of stay and/or readmission rates. Facilities that perform well receive "Gold Card" status for a period of time. These facilities are exempt from the concurrent review process and handle all aspects of discharge planning. We'd like to introduce something similar for our Nebraska program once enough data is available to identify the appropriate facilities and metrics to use.
Data-informed Coordination	We monitor discharge plans for compliance and build in interventions when data shows gaps in care. So when our data shows, for instance, a failure to keep an aftercare appointment or fill critical prescriptions, care coordinators can do the appropriate follow-up to help members get back on track with their plan.

The Interdisciplinary Team: Coordinating Among Discharge Planners and Providers

The first step to ensuring seamless coordination among providers and discharge planners is identification of members in need of more complex discharge planning based on their acuity of risk for readmission post-discharge if not provided the right supports. WellCare employs a screening tool that is completed by one of our utilization management nurses at the time of admission. This tool is tailored to specific populations such as adult, pediatric and maternity and to conditions such as neo-natal intensive care or behavioral health. Based on the risk score for the member, we deploy discharge supports, which could range from telephonic support and planning of facility-based discharge efforts to deploying field-based care managers into the facility to work directly with members, caregivers and the varying levels of service providers. Ideally, with permission from higher volume providers, we would place a concurrent review nurse in the facility to help facilitate these efforts and seamlessly pass the most complex cases to our field-based care management staff so we can conduct home safety evaluations as needed and the member is supported once he or she leaves the hospital.

For members receiving transplant services, we automatically deploy our Catastrophic Case Rounds at least 15 days of the transplant to begin planning for a successful discharge. Catastrophic Case Rounds

include an interdisciplinary care team of social services, field case management, behavioral health clinicians and the medical director. During these rounds, risks and barriers are identified and strategies developed for mitigation of those risks. A successful example of WellCare's discharge planning innovations can be found below.

SUCCESSFUL DISCHARGE PLANNING

A Success Story from WellCare's Affiliate in Hawaii, known as 'Ohana

WellCare's affiliate in Hawaii implemented a program called After Hospital Outreach Programs (AHOP). This program is based on a partnership between WellCare and several high volume hospitals to decrease hospital readmissions. The first diagnosis piloted for this program was Congestive Heart Failure (CHF) one of the most common diagnoses for readmission with WellCare's membership. In order to strengthen our ability to reach our members, WellCare also partnered with the state Office of Aging (OOA) to offer a similar support program. The OOA team provided outreach to a member for up to six months to ensure a safe discharge and prevent readmissions. We alert the OOA of any high-risk pending discharges so they may include our membership in their program. In these cases WellCare is able to use a health coach to perform an in-hospital visit to introduce the program and perform a home visit within three-to-five days of discharge from the hospital and follow-up calls. *Preliminary first data for the program shows 47 referrals for CHF, Diabetes, Asthma and CAD with 28 enrolled in the program. Of these members, only 3 had a readmission.*

WELLCARE'S APPROACH FOR MEMBERS DISCHARGING FROM STATE PSYCHIATRIC HOSPITALS

This same basic model of Catastrophic Case Round used for transplant patients will be deployed for SMI members being discharged from a state psychiatric hospital. Case Rounds will focus first and foremost in meeting basic needs of the patients. Some key elements of our strategy are outlined below.

Evidenced-Based Community Services: Our Transition Care Coordinators specially trained in behavioral health will coordinate with the Regional Behavioral Authority that serves the community to which the member is being discharged to facilitate the best options of locally-based recovery-focused community services. Many members coming from longer-term care may benefit, for instance, from Assertive Community Treatment (ACT) to help them transition to the community setting. For members transitioning to Omaha, Lincoln and the Tri-Cities area where ACT teams are currently operating, we will evaluate members to see if they meet criteria and can benefit from those services. In those cases where a member enters the ACT program, the ACT team will take a lead role in coordinating the discharge in consultation with the member, the WellCare team, the discharge facility and other health professionals as needed and appropriate.

Access to Social Service Planning: Care coordinators engage our CommUnity Advocates and CommUnity Assistance Line to help find resources to mitigate barriers to a successful transition to the community. For instance, we often find members discharging from psychiatric hospitals face unique challenges with housing support. Our unique cataloging of social service providers allows us to find resources in communities across the state where members may be moving. We also work with members to set their own recovery and wellness goals as part of the discharge planning process and identify community-based services that can be engaged prior to discharge to help ease the transition for members.

Medication Adherence: Members get assistance with understanding their medications and WellCare associates can help members through medication reconciliation and compliance. Helping to ensure our SMI members take their medicines as prescribed is a critical step to keeping them from an unnecessary emergency room visit after they discharge.

Peer Support Specialist Transition Program: To enhance our hospital discharge services, WellCare of Nebraska will implement a Peer Support Specialist Discharge Planning Program in partnership with the Regional Behavioral Health Authorities and others. We know in our meetings with the Nebraska Association of Behavioral Health Organizations (NABHO) that there are opportunities to expand the use

of peers to serve our SMI members. In our program, the primary role of a Peer Support Specialist is to offer support in navigating community-based care and acting as a mentor by offering hope and strength while achieving recovery. The Peer Support Specialist works to develop a trusting relationship with the member while offering encouragement to continue compliance with treatment. Peer Support Specialists will be part of the member's coordinating treatment team.

WellCare's approach for children discharging from Residential Treatment

WellCare intends to deploy a Foster Care Care Management Team in Nebraska modeled after our Kentucky affiliate's highly successful program. As it relates to discharge planning, our systems will identify members in our specialized care management program so utilization management nurses and transition care coordinators will work with specially-trained care managers to ensure the specialized needs of foster children with Serious Emotional Disturbances exiting residential treatment are addressed.

The basics of our Foster Care Care Management program is assessing every child's needs and working with individual providers to build a trauma-informed, community-based package of services to meet those needs. With MLTC's addition of strong community-based options like Multi-Systemic Therapy, WellCare is eager to see those services grow in communities across the state to provide discharge planners more options. We welcome the opportunity to work with MLTC, the Division of Children & Family Services, the Division of Behavioral Health and the other selected MCOs to build a statewide strategy to support the growth of these mid-level community based services that are key to ensuring children leaving residential treatment have a full continuum of services available to help them succeed in the community.

Continued Follow-up and Monitoring of Discharge Plan, particularly for members in Remote Areas

WellCare's Transition Care Coordinator Team follows up with members and uses personal calls or visits along with claims mining to confirm appointments are kept. All members with a discharge plan will receive welcome home contact. Members with more acute needs will receive in-person welcome home visits to make sure the discharge plan is well understood and the services are in place to make for a successful transition to home. Our care gap reporting also empowers Primary Care Providers (PCPs) to play an important role in reaching individuals in remote areas for follow-up after discharge. We share data with PCPs on readmission rates, and help them understand through our Clinical HEDIS Practice Advisors (CHPAs) program, steps they can take to improve follow-up with their patients.

We are placing Welcome Rooms in areas across the state and will be hiring staff living in the communities where our members live. These direct contacts will help us ensure members in remote areas of the state have access to field-based care management when they need it. Additionally, in more remote frontier areas of the state, telephonic support will be supplemented with support identified through community resources as well as telemonitoring if appropriate.

Value-Add: Deploying the Discharge Model for Post-Incarceration

WellCare has been closely following Nebraska's discussions about the need for stronger coordination of care for members being released from the correctional system. Knowing that a large number of these members exiting incarceration are in need of coordinated behavioral health services, WellCare would like to work with the Department of Corrections, the Division of Behavioral Health, the Regional Behavioral Health Authorities and MLTC to deploy our discharge planning model with effective early identification of members in need of such coordination, continuous planning as payer sources transition from corrections to Medicaid, and technical support on trauma-informed care that best serves members with complex and co-morbid behavioral health conditions.

SECTION IV.L CARE MANAGEMENT

65. Describe how the MCO will use data and evidence-based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies. Discuss how these tools and data and systems will be integrated to implement outcome- and value-oriented payment models. Describe the MCO's experience and specific results. *(Page limit 5 pages)*

USING DATA AND EVIDENCE-BASED DECISION SUPPORT TOOLS

WellCare is, fundamentally, a data-driven organization using a broad array of decision support tools internally and with provider and stakeholders to drive appropriate engagement of care management protocols and a wide set of data points to drive improved health outcomes and create cost efficiencies.

A sampling of the decision-support tools and data sets we use include:

- Predictive modeling for provider, member and health care system behavior based on utilization and quality data
- Chronic Illness and Disability Payment System (CDPS) model used to stratify members based on risk and acuity scoring
- Health Risk Assessments
- Care Gap Reporting
- Heat Mapping of Care Gaps
- HEDIS performance metrics
- Retrospective Review Reports
- Retrospective Drug Utilization Review (rDUR) Reports
- Pharmacy Tool Box
- Clinical Practice Guidelines
- Utilization Reports (Acute, Emergency Department, Pharmacy, Residential, Outpatient)
- Health*Connections* Referral Tracking
- Public Health Reporting and Heat Mapping
- Outcomes/Performance Reporting of Social Services Network
- Readmission Risk Assessment (i.e. Lace tool)
- Medical Record Review
- Grievance and Appeals Trends Reporting
- STARS® SOLUTIONS Analytical Tools to identify outliers and trends for fraud, waste and abuse (FWA) monitoring
- Member satisfaction scores
- Provider satisfaction scores
- Performance Improvement Project metrics and monitoring
- Behavioral and Clinical Risk Stratification Tools including CAGE, PHQ-9 and SPF-12
- Pregnancy Risk Assessment for all pregnant members

Using Data and Decision Support Tools within WellCare to Maximize Care Coordination

Once a member is enrolled in WellCare, we use a proprietary scoring algorithm on all active members to identify care management needs. Each member is assigned a score based on several components. In addition to being assigned a score, the members are also flagged when specific conditions exist that are likely to be positively impacted by care management. The scoring of members is based on three primary drivers: clinical severity, utilization and cost, as described below. Each driver is a separate process that is performed on each member based on a rolling 12-months of medical and pharmacy claim history.

- **Clinical severity:** This portion is based on the Chronic Illness and Disability Payment System (CDPS) model, a diagnostic classification system developed by the University of California, San Diego. This Statistical Analysis System model classifies every diagnosis code on a claim and assigns a score based on the severity of the diagnosis. The CDPS model also examines pharmacy utilization as a component of risk scoring. We use this model as a way to classify members by risk of adverse outcomes.

- **Utilization:** This portion of the model uses a number of utilization indicators and applies a weighted score based on input from the clinical services team. The metrics tracked are hospital admissions, emergency room visits, PCP visits, specialty visits, acute admissions, home health visits, and rehabilitation visits.
- **Cost:** The cost portion scores each member based on his or her relative, normalized PMPM as compared to the other members within the program. The cost component looks at inpatient, outpatient, and professional costs.

Additionally, we use a number of behavioral and clinical risk stratification tools and data including CAGE, PHQ-9 and SPF-12 to identify members with behavioral health co-morbid needs to make a decision about the primary care management program they should be assigned to – behavioral or physical health.

Using Data and Decision Support Tools within WellCare to Improve Outcomes

The overarching goal of our Care Management program is to improve our members' health outcomes, enhance their quality of life and ultimately reduce their need for more restrictive and costly acute health services. Below is a sampling of tools we use internally to drive improved outcomes.

Over and Under Utilization Monitoring: Our Medical Economics team routinely produces and analyzes utilization reports that use authorization, claim, and encounter data to allow us to systematically identify and address emerging trends or changes in utilization. The reports include, but are not limited to, admits per thousand by type (medical/surgical, deliveries, NICU, psychiatric), days per thousand by type, C-section rate, NICU average length of stay, catastrophic rate, readmission rate, and emergency department usage by provider, member, hospital and diagnosis. The team compares results to established goals as well as benchmarks or targets. Data analysis includes statistical models that identify patterns of inappropriate ER use, office visit up-coding, and improper billing patterns. Our State Medical Directors contact outlier providers to address specific issues identified and review clinical guidelines, where applicable. The utilization data is reported to the Utilization Management Committee where they discuss trends and recommendations for broad action.

Examining Pharmacy Utilization: Our retrospective drug utilization reviews (rDURs) are designed to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and members associated with specific drugs or groups of drugs. WellCare performs rDUR projects throughout the year to improve the quality of health services provided to our members. ***One example is related to a pattern of under-utilization of chronic inhaled corticosteroid (ICS) inhalers among members using short-acting beta agonist (SABA) inhalers. Our pharmacy team implemented provider-directed interventions aimed at improving the use of ICS inhalers consistent with evidence-based guidelines. Post-intervention, more than 8 percent of members identified in the initial measurement had a claim for an ICS inhaler, suggesting the intervention was effective.***

Examining Trends with Adherence to Guidelines: We regularly evaluate utilization of recommended preventive services, chronic disease management services and acute care. We systematically mine membership data to identify trends in adherence to recommendations. Annually, in accordance with our medical record review policy, our Quality Improvement department conducts medical record reviews on a random sample of charts from primary care providers. Our medical record audit assesses physician compliance with recommended preventive health and clinical practice guidelines. We also assess and trend provider compliance with guidelines through annual administrative data and medical record reviews for HEDIS. An example of successful application of this method can be found below.

WellCare Experience and Specific Results

Improving Follow-up Rates for children prescribed adhd medication

Our use of data and decision support tools to examine trends in adherence to clinical guidelines has allowed us to make improvements in the care provided to our members. For example, in Georgia, we identified opportunities to improve follow-up care for children prescribed ADHD medication. By implementing formal guidelines, conducting ongoing, targeted provider and member outreach, and monitoring adherence, ***we increased the percentage of members who had one follow-up visit with the prescribing authority during the 30-day initiation phase from 39.39 percent in 2013 to 48.92 percent in 2015.***

Using Data and Evidence-Based Decision Support Tools to Work with Providers

Our provider partners play a critical role in helping us maximize care coordination, improve outcomes and create efficiencies, so we use a number of tools and data sets directly with providers to highlight individual opportunities by member and by their practices as whole. Some of those tools and data sets include, but are not limited to:

- HEDIS Care Gaps, Quality and Segmentation Reports
- Clinical Practice Guidelines
- Provider Portal Tool
- Medical Record Review Tools
- Utilization Reports (i.e. Emergency Department and Acute Care)

HEDIS Care Gaps and Segmentation reports are generated monthly using available claims and encounter data to monitor provider performance and identify areas of improvement. The reports identify members in specific Provider Groups, IPA's and by individual physicians' level who have gaps in preventive and/or chronic condition care so the gaps can be addressed. WellCare's Clinical HEDIS Practice Advisors (CHPAs) and Provider Relations (PR) Representatives use the care gap reports to help provide education and outreach to provider offices in an effort to ensure members are receiving the preventive and chronic care services they need and are missing. ***Recently, we expanded our care gap reporting tools to include heat mapping of care gaps so we can identify geographic trends in care gaps and target the efforts of our CHPAs based on area needs.***

Medical Record Reviews are used to a review contracted practitioner office medical records utilizing criteria based upon government sponsored contractual requirements and federal and state regulations. The medical record review is conducted to assess the quality of care delivered and documented. The process includes, but may not be limited to, evaluation of adherence to Early Periodic Screening, Diagnostic and Treatment (EPSDT) or Child Health Check-up Visits (CHCUP) requirements, provisions for continuity of care, adult preventive care rendered, identification of quality of care events, treatment for members with special health care needs, compliance with regulatory reporting requirements, and compliance with coding practices.

Provider Profiles are self-management tools providers can use, as well as tools WellCare CHPAs and PRs use to walk providers through their relative quality, utilization, care gap, administrative and cost data. In order to enhance the support we offer our providers, WellCare is building expanded Provider Profile reports that will include a greater emphasis on episodic, condition-specific reports. The reports will integrate clinical, administrative (e.g. pharmacy, behavioral health, and medical claims) and between clinical and administrative data to identify rates of gaps in care delivery, the average cost of care by episode, and measures of cost and quality performance.

Data and Evidence-Based Decision Support Tools to Inform Value-Based Purchasing

Our value-based purchasing (VBP) philosophy is focused on aligning incentive payments with quality outcomes. In identifying performance measure and initiatives used in VBP arrangements, we look at:

- Performance measures established by state partners
- Population health priorities for the members we serve
- Data analytics that identify prevalent conditions, areas of greatest need, and areas of potential impact

We have found that 10 to 12 performance measures delivers an effective value-based purchasing program so we prioritize the measures used to ensure we focus on those areas with the greatest need and opportunity for improvement. For our Nebraska program, our incentives will vary based on the specific provider and the membership they serve. Our value-based purchasing incentives will be informed by MLTC's priorities as well as our own data analytics. Some of the key measures we anticipate targeting are shown in **Figure 15**, by provider type.

Figure 15

Provider Type	Sample Incentives
PCPs	➢ Childhood immunizations ➢ Well-child visit in first 15 months of life ➢ Immunizations for adolescents ➢ Developmental screening in the first 3 years of life ➢ Well-child visits in the 3rd through 6th years of life ➢ Adolescent well-care visit ➢ Cervical cancer screening ➢ Chlamydia screening in women ➢ Flu vaccinations for adults age 18 and older ➢ Screening for clinical depression and follow-up plan ➢ Adult body mass index assessment ➢ Medical assistance with smoking and tobacco use cessation
Behavioral Health Home	➢ Follow-up after hospitalization for mental illness ➢ Adherence to antipsychotics for individuals with schizophrenia
Obstetricians	➢ 6 or more prenatal visits before delivery ➢ Postpartum visit within 6 weeks of delivery ➢ Evidence of pre-delivery pertussis vaccination ➢ Completion of required screening tool by end of the second trimester
Specialists	➢ Use of spirometry testing in assessment and diagnosis of COPD ➢ Pharmacology management of COPD exacerbation
Hospitals and Health Systems	➢ All-cause readmissions ➢ Timely transmission of transition record

Data and Evidence-Based Decision Support Tools Working with Stakeholders

WellCare's approach to using data and evidence-based decisions support tools to engage with stakeholders, advocacy groups and the social safety net at-large is built into our one-of-a-kind proprietary Health***Connections*** Model. WellCare's **Advocacy and CommUnity-Based Programs** department maintains the technical systems to capture access and use of social services by members and their families at the transactional level. In addition the team assembles community-based, public health data on which to identify health trends that could impact our membership. And, using the social service referral data, we identify potential gaps in social service availability to pilot community-based solutions for filling those gaps for our members, the families and the communities-at-large. The primary focus of this team is to create greater transparency of the social safety net and its positive impact on health outcomes.

An example of the use of data to drive stakeholder engagement and our CommUnity Advocacy priorities is the use of public health data to identify risk patterns for our members.

Figure 16

Food Insecurity

The United States Department of Agriculture (2014) estimates that one in five children and one in seven adults in Nebraska face food insecurity. The Nebraska Food Bank Association reports that low-income families in Nebraska must choose between buying food and paying bills. See **Figure 16** for limited access by county.

WellCare attacked the issue of food insecurity head on by creating a Healthy Food Access Initiative. By aligning all the community engagement strategies around the topic of healthy food access, WellCare accomplished the following in 2014 across 12 different states:

CommUnity Activities

- Hosted or participated in 803 total activities related to nutrition and healthy food access reaching nearly 600,000 people
- Collaborated with more than 18,000 community stakeholders related to nutrition and healthy food resources

Social Service Utilization Support

- Referred more than 800 people to more than 1,400 local, community-based nutrition and healthy food resources
- Bridged more than 50 gaps in needed nutrition and healthy food resources

CommUnity Health Investment Program

- Launched seven healthy food access programs in three states to increase participation in WIC/SNAP by doubling benefits at Farmers Markets
- Increased access and purchase of healthy food options by 85 percent among more than 65,000 participants

WELLCARE'S EXPERIENCE AND SPECIFIC RESULTS IN USING DATA AND DECISION SUPPORT TOOLS

New York Quality Medicaid Improvement: In calendar year 2012, 72 percent of the New York Medicaid QHP HEDIS® measures were at or below the 50th percentile. A Root Cause Barriers Analysis, focused on measure and county specific intervention activities, was conducted, and an integrated team approach was developed and care gap closure targets in areas with high volumes of open care gaps were prioritized. The field-based Quality and Provider Relations team drove change by engaging, educating and influencing providers through a collaborative, face-to-face and telephonic outreach. These teams collected, summarized and trended provider performance data to identify and strategize opportunities for provider improvement. ***Because of this activity, in 2014 WellCare of New York was ranked in the top quartile of plans; up from 11th out of 16 the previous year. The net results were that 70 percent of the practices were at or above the 75th percentile and 35 percent of the practices were at the 90th percentile for the HEDIS® Prevention Scores. Additionally, 71 percent of the practices were at or above the 75th percentile and 42 percent of the practices were at the 90th percentile for the HEDIS® Treatment Scores.***

SECTION IV.L CARE MANAGEMENT

66. Provide a proposed plan for coordinating efforts for members who may be involved in multiple State programs, including those enrolled in HCBS waivers. Describe how the MCO will deploy care management activities under this RFP in a manner that will not duplicate the activities provided under HCBS waivers and will facilitate sharing of information across DHHS-administered programs. *(Page limit 3 pages)*

PROPOSED PLAN FOR COORDINATING FOR MEMBERS INVOLVED IN MULTIPLE STATE PROGRAMS

As a health care company focused on serving members in Medicaid and Medicare for more than 20 years, WellCare works with individuals with complex needs including those in Home and Community-Based Services (HCBS) waiver programs, dual-eligibles, individuals with developmental disabilities, the aged, blind and disabled population, children with special health needs and children in foster care. These populations often have multiple physical health, behavioral health and social services needs that require a diverse set of solutions to serve, which is one reason we deploy a flexible care management model that is grounded in core person-centered, data-driven, interdisciplinary care principles but can be adjusted to respond to individual situations.

Our proposed plan for coordinating for members involved in multiple state programs including HCBS waiver programs in Nebraska includes several key features:

- Tagging of members in these programs through our Medical Management Platform, which provides any staff member engaged with the member a full view of that member's profile
- Specific policies, procedures and work flows designed for working collaboratively with agencies or waiver care coordination programs
- Specific training for care management on these programs in Nebraska, including internal process and workflows for joint service/care planning
- Designating WellCare of Nebraska points of contact for various agencies involved in formal care coordination for our members
- Use of a clinical liaison position to provide support and training to waiver care coordinators rather than direct care management to members who have existing care coordinators
- Meetings with organizations involved in HCBS waiver care coordination to develop defined delineation of responsibility and cadence of touchpoints and involvement
- Development of data-sharing protocols and defined timelines to ensure we both receive important information about a member's condition timely so appropriate interventions can be made
- Development of joint protocols for communication with members to minimize confusion

Specific Policies, Procedures and Workflows and Training of Staff on Joint Service Planning

WellCare's Care Model is ideally designed for working across multiple state and waiver programs, as we already engage in integrated care planning as part of our core programming. The Interdisciplinary Care Team (ICT) is a foundational feature of our care model. This team, centered on the member and his or her caregiver, consists of WellCare care management staff, primary care providers (PCP), specialists and, notably, representatives from other support or state programs in which the member may be engaged. Our care model is flexible enough that we can facilitate the ICT process or participate in the process if it is facilitated through the member's involvement in existing care coordination activities.

We will base the development of specific policies, procedures and work plans for working with members already engaged in care coordination through other programs on the ICT concept, and staff training will incorporate specifics on Nebraska's waiver programs and our engagement in it. Our processes will be developed with input from stakeholders including agencies doing waiver services coordination and our

policies, procedures and work flows will be distributed to MLTC for approval. WellCare will also support and can help inform a multi-payer solutions working across Medicaid Managed Care Organizations in Nebraska to develop single referral forms and/or other common processes to mitigate agencies having to navigate multiple processes and forms.

Designation of Points of Contact and Clinical Liaisons

We will designate points of contact within our WellCare of Nebraska staff for outside agencies doing care coordination for our members. Our protocols will have specific turn-around times for response by the designated point of contact as well as policies for documentation and follow-up.

We also believe in partnering with existing care coordination programs on fostering proven care management principles, and support them through assessment, planning and monitoring, particularly through data sharing. We are introducing in Nebraska the concept of a clinical care liaison, which provides support to existing care coordination programs rather than direct care management to members. This is model will provide an integrated program, particularly with behavioral health members and Independent Practice Associations (IPA). Many of the Community Mental Health Centers we work with already have some level of care coordination services for members with Serious Mental Illness (SMI). Because of this experience, we work with the CMHCs to support their efforts through training and data sharing, while also ensuring members don't face multiple care managers and multiple care plans. As more providers form IPAs or become Patient Centered Medical Homes or Integrated Health Homes, WellCare continues to flex our care management programs to support provider-led care coordination as it is available for members and as it meets the full spectrum of their needs.

DEPLOYING CARE MANAGEMENT WITHOUT DUPLICATING ACTIVITIES

We are basing our Nebraska strategy to avoid duplication of services for members in HCBS waiver programs on successful programs deployed in our Hawaii affiliate, 'Ohana, which serves individuals with developmental disabilities, Aged, Blind and Disabled (ABD) population, as well as those involved with various state programs. 'Ohana routinely works with Hawaii's Adult Mental Health Division, Child and Adolescent Mental Health Division, Department of Education, Department of Health and Public Health Nurses on individual cases. Additionally, 'Ohana manages multiple state programs for Hawaii that cross over through various waivers and multiple programs that has required them to develop specific plans to coordinate care without duplication.

Lessons learned from 'Ohana have informed our plan for deploying care management activities for members already engaged in some level of care coordination through other agencies:

- A clear delineation of responsibilities should be outlined at a programmatic level and specifically reinforced in each individual care plan effort
- Open communication with direct access between care coordinators is critical to implementation
- Formal processes must be in place around member engagement to mitigate member confusion
- Because different sets of benefits and services are available through different programs, a clearly defined division of services that can be easily communicated to members so they understand who is responsible for which services
- Collaboration must also occur at the program level to ensure that both organizations have aligned their level of expectations

Collaboration at Work: An Example from WellCare's 'Ohana Plan

In Hawaii, when one of 'Ohana's programs (managing care for members with Developmental Disabilities) first went live in 2009, they experienced some confusion on how to work with Developmental Disability department case managers. Through a process of joint meetings and ongoing touch points used to this day, 'Ohana staff members lay out the difference in "primary" responsibilities

between service coordinators and care managers. They used the same processes to help define responsibilities with another program they manage known as the Community Care Services (CCS) program, which focuses, in part, on members with Serious Mental Illness.

'Ohana's Service Coordination team works collaboratively with the CCS program's Care Management team. We have procedures in place that set expectations for service coordinators to work in partnership with both CCS program staff and BH community case managers (BHCCMs). The first step is to determine which 'Ohana members are enrolled in the CCS program. We achieve this by flagging members identified as CCS members with an identifier in their clinical record. 'Ohana service coordinators are trained to look for this identifier, as coordination with BHCCMs is necessary for successful service planning.

Figure 18

'Ohana Service Coordinators' Collaboration With CCS

While BHCCMs are considered the "primary" case managers for members, we believe the collaboration with our service coordinators provides for truly integrated medical and BH care and better health outcomes. As depicted in **Figure 18** the touch points for this joint collaboration are:

- Assessment and treatment planning
- Sharing service plans
- Coordination of primary and BH care
- Maintenance of Medicaid eligibility
- Housing placement and maintenance
- Participation in ICT meetings for members with complex comorbid disorders
- Discharge planning and post-hospital follow-up
- Promotion of medical screenings for early detection of side effects from long-term use of psychiatric medications

Data Sharing: They Key to Collaborative Care Coordination

WellCare recognizes the need to share data with our joint collaborator programs to drive intervention on behalf of members in as real-time as possible. We will provide data such as PCP visits, care gap reports, emergency department utilization, acute admission and other requested clinical data requested through the joint service planning/interdisciplinary care team process.

Additionally, we would like to work with agencies to receive data and information and make it part of the member's record within our Medical Management Platform (MMP) system to give a more robust and clear picture of each member's needs, interventions and experience with the health care and social services systems.

SECTION IV.L CARE MANAGEMENT

67. Describe the MCO's outreach program to encourage women to seek prenatal services during their first trimester of pregnancy and how the MCO will implement required health risk screening and follow up, when applicable, for pregnant members. *(Page limit 2 pages)*

MEETING MEMBERS WHERE THEY ARE: WELLCARE'S PRENATAL OUTREACH PROGRAMS

WellCare recognizes that reaching a mom-to-be in her first trimester gives us the best chance to help her have a healthy pregnancy and positive birth outcome. This is why we place a premium on identifying pregnant members early, connecting with them and empowering and educating them.

Experience Matters

More than 54,000 people have attended a WellCare Baby Shower or other maternal education event.

WellCare and our affiliates across the country have extensive experience in building Prenatal Care Management Programs, including for women with complex medical needs or co-morbid behavioral health conditions. Our Nebraska Prenatal Care Management Program will be modeled after our successful program in Georgia where we manage an average of 27,000 deliveries annually.

Key to our success is the early identification and prioritization of our most vulnerable pregnant members. At the early prenatal level the effort is focused on:

- Increasing the number of pregnant women identified in the earliest possible timeframe
- Offering education and information on available resources, health and wellness topics including smoking cessation and access to medical, behavioral and social services
- Ensuring and facilitating access to quality health care including connection to prenatal OB services
- Incentives for meeting healthy milestones in their pregnancy care

Identifying Pregnant Members through Health Risk Screening and Follow-up

Each new member in WellCare's Heritage Health plan will receive an initial Health Risk Screening (HRS), which, among other things, assesses a member's pregnancy status. Because of our focus on serving members in government-sponsored healthcare programs, we deploy multiple methods for reaching members to conduct the HRS, which includes:

- Telephonically through the initial Welcome Call
- By mail, in the Welcome Packet
- On the Internet at WellCare.com/Nebraska

WellCare's prenatal program uses a multifaceted approach to identify existing members who become pregnant, including:

- Provider notifications and referrals
- Self-referrals
- Claims-based identification
- Health risk assessments
- State-based referral files (when available)

Once identified, either through the welcome process, health risk screening process or any of the methods identified above, members are then flagged for prenatal services including, but not limited to, a number of interventions based on individual need and risk factors for a high-risk pregnancy or poor birth outcome. Members triggered as pregnant will receive a pregnancy-specific risk assessment to determine if they meet evidenced-informed criteria for care management services. Those identified as low risk will get, at a

minimum, a call mid-pregnancy and postpartum to check in and ensure no change in their level of need. Those found at high-risk will receive the full array of complex care management service with a registered nurse specially trained in high-risk pregnancies.

Results Matter

In our Missouri Care affiliate, efforts to support women with high-risk pregnancies reduced NICU days by 30 percent in one year alone.

Innovative Strategies to Encourage Prenatal and Postpartum Care Services

WellCare will deploy several strategies to encourage our Heritage Health members to obtain health care services that reinforce our prenatal program goals, help eliminate barriers to care and optimize compliance with scheduled prenatal visits and return for postpartum checkups including:

- **Free community baby showers** are open to expectant and new mothers, plus one guest. Nationwide, we have conducted 1,865 baby showers or other prenatal education community events since 2013, focusing on providing moms with critical heath care information for themselves and their babies. Members also receive a gift basket, an opportunity to participate in a raffle and refreshments. The community baby showers also connect moms with organizations that can help address the social issues, such as the Women Infants and Children (WIC) program.
- **Educational materials** including the Mommy & Baby Matters and Journey through Pregnancy booklets are issued to all members and our website offers additional educational materials.

- **Incentive programs** reward members for healthy behaviors by promoting member and caregiver education and empowerment, while eliminating barriers so they may be active, informed participants in the health care process. Our Maternity Education and Reward Program (MERP) provides basic prenatal, postpartum and new born care educational materials to all of its pregnant and newly delivered Medicaid members, and rewards them for compliance with doctor and wellness visits with gifts such as a stroller or play yard.
- **Provider partnerships** are very important to encouraging pregnant women to seek prenatal and postpartum care services. WellCare rewards desired practices through pay-for-quality incentives and conducts provider outreach letters alerting the provider of patients who need necessary care. In one of our affiliates, we have launched a P4Q program raising rates for Medicaid deliveries to the average commercial rate in the market as long as providers hit several key milestones such as prenatal visits as well as outcomes targets including mitigating preterm births and long NICU stays.
- **WellCare's CommUnity advocates** collaborate with our social workers to identify and procure resources such as housing and food supports to help stabilize a member's socio-economic barriers so that she is able to place focus on her health and the health of her baby.
- **Member self-service** offers member-initiated support and services that have the convenience of being accessible anytime to support their questions on selecting a provider or transportation. This includes the Nurse Line, which is available 24 hours a day, seven days a week, with personalized help to set up doctor visits and schedule transportation. ***This also includes Text4Baby – a free mobile information service, which is an educational program of the National Healthy Mothers, Healthy Babies Coalition.***

IV.M Quality Management

SECTION IV.M QUALITY MANAGEMENT

68. Provide a description of the MCO's proposed QAPI program. Include the following in the description:

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

(Page limit 10 pages)

BUILDING A CULTURE OF QUALITY ACROSS THE OPERATIONS

WellCare's core mission is to provide for high-quality care that improves our members' well-being as well as enhance population health outcomes for the communities we serve. To achieve this goal, WellCare has adopted a culture of quality that is integrated into every element of our operations. We provide a broad range of well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and program performance by partnering with members, providers, community-based organizations, and state and local agencies to provide for holistic, person-centered, evidence-informed and evidence-based high-quality health care. These efforts are supported by our comprehensive, systematic, data-driven quality assurance and performance improvement (QAPI) Program as further described in the sections below.

Quality Improvement Objectives

Our quality strategy focuses on six fundamental attributes we expect within our systems of care:

- **Safe:** We monitor and evaluate our health care delivery systems with an aim of connecting members to care which is helpful and not harmful.
- **Effective:** We update our clinical practice guidelines (CPGs) and audit our provider network's adherence so everyone remains aware and utilizes current scientific, evidence-informed practices.
- **Person-Centered:** We maintain systems that are designed to connect our members to culturally, socially and linguistically appropriate medical, dental and behavioral health care. It is important that our members are empowered to play an active role in health care decision-making.
- **Timely:** We aim to reduce unintended delays and we monitor our network by tracking the accessibility, availability and promptness of medical care.
- **Efficient:** We seek to reduce waste within our system by creating value, monitoring health outcomes relative to cost and minimizing errors. Using the Plan Do Study Act (PDSA) approach, we identify and implement strategies to improve quality, appropriateness and accessibility of member health care.
- **Equitable:** We establish safeguards to assure that our members, regardless of race, age, ethnicity, primary language, geographic residence, or socioeconomic status, receive the highest level of quality care.

Through this response, we will describe how we structure the QAPI Program and how we integrate the key quality objectives into our operation, providing support across the board for members and providers to improve health outcomes. This includes details of our quality infrastructure and accountability, QAPI

processes, collaboration with the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) Quality Strategy and the comprehensive use of data to design, implement and evaluate all of our programs.

WELLCARE'S QUALITY STRUCTURE: LAYING THE FOUNDATION FOR A HIGH-QUALITY PROGRAM

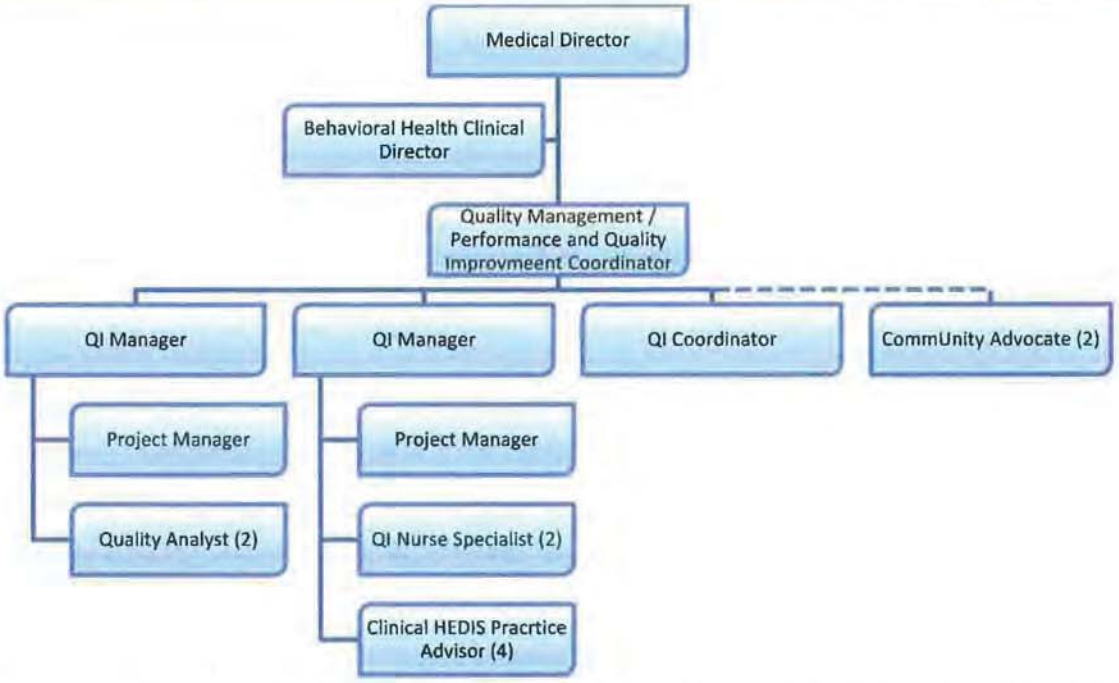
WellCare devotes significant resources to QAPI activities. Led by our Chief Medical Director of Quality, WellCare's corporate quality department supports national program design, data collection, data analysis (e.g. run charts, heat maps), and reporting functions for all of our affiliate plans. WellCare will also locate an in-state Quality team with robust staffing to monitor multiple areas of clinical and service performance, prioritize problem areas for resolution, design strategies for change, collaborate with state and local partners, implement improvement activities, support providers toward those improvements and measure the success of interventions. The local team will be fully supported by the power of WellCare's corporate infrastructure which provides for the medical economics, data informatics, analysis and reporting necessary for any QAPI Program to be successful.

Locally-Based Quality Activities Drive our Quality Improvement Programs

All of our Nebraska QAPI activities will be overseen by WellCare of Nebraska's medical director in coordination with our Nebraska-based behavioral health clinical director and quality management/performance and quality improvement coordinator as illustrated in our model staffing chart shown in **Figure 1**. Quality improvement activities are separate from, but integrated with utilization management and case management activities.

Figure 1

Quality Assessment and Performance Improvement Staffing and Organization



Quality Department Functions: The Quality department staff will collaborate with associates across departments to evaluate quality of care and to identify opportunities for improvement. ***WellCare has an integrated model of resources supporting the QAPI Program, including behavioral health.*** These resources include associates crossing all functional areas of the organization, including, but not limited to, the executive team, disease management, data analytics, provider relations, network development,

compliance, grievance and appeals, utilization management, case management and community outreach.

The Quality department infrastructure roles and responsibilities support WellCare's goals for a program of continuous improvement as outlined below:

- The **medical director** will be a full-time position and will be a practicing and licensed physician in good standing in Nebraska. The medical director will have key responsibilities as the leading medical and clinical voice of the program. Among these critical roles is oversight of all aspects of the QAPI program, including: acting to continuously improve the overall effectiveness of the QAPI Program; overseeing appropriateness and effectiveness of clinical care provided by WellCare; developing and maintaining CPGs along with the Clinical Advisory Committee in collaboration with WellCare's corporate Medical Policy Committee; educating and overseeing adherence of the CPGs by the clinical staff and network providers; conducting and overseeing clinical QAPI committees and reviewing findings; analyzing, verifying and attesting to all clinical data and reports submitted to MLTC; leading the Quality Assurance and Performance Improvement Committee (QAPIC); and participating via telephone or in person (at MLTC's discretion) at every Quality meeting with MLTC and other system partners, and as requested by MLTC.
- The **behavioral health clinical director** will be a practicing licensed psychiatrist or psychologist who reports to the medical director and has the responsibility for the following QAPI initiatives from a behavioral health perspective. The BH clinical director will oversee the implementation of the behavioral health aspects of the QAPI Program; monitor and identify opportunities for improvement of the overall effectiveness of the QAPI Program; oversee appropriateness and effectiveness of behavioral health care provided by WellCare; and participating on the QAPIC to ensure behavioral health quality initiatives are fully integrated into the spectrum of the QAPI Program
- The **quality management/ performance and quality improvement coordinator** will be responsible for providing leadership and direction to the Quality department to ensure that WellCare quality objectives are met. The coordinator will develop, coordinate, and implement WellCare quality strategies and interventions, including the collection of relevant and meaningful indicators for monitoring and evaluating the quality and appropriateness of care/ service across the continuum. After completing the prior year's QAPI Program Evaluation, the coordinator will work with the interdepartmental leadership team to develop the QAPI Program Description and QAPI Work Plan. The quality management/ performance and quality improvement coordinator will also serve as MLTC's contact person for quality performance measures. In that role, the coordinator will focus organizational efforts on the improvement of clinical quality performance measures, utilize data to develop intervention strategies to improve outcomes, develop and implement performance improvement projects, both internally and across Heritage Health MCOs, and report quality improvement and performance outcomes to MLTC. The coordinator will collaborate with Nebraska-based and corporate supports to ensure Nebraska has necessary analytics and reporting to meet state requirements as well as the needs of the QAPI Program in general.
- **Quality improvement managers** will oversee Clinical HEDIS® Practice Advisors (CHPAs) and/or other QAPI staff members.
- **Quality improvement nurse specialists** will be responsible for coordinating the review of quality of care issues with the medical director and generating the Patient Safety report. The QI nurse specialists will review data from medical record audits for CPG compliance. In addition, the specialists will complete QI analyses to support performance measures for NCQA accreditation.
- **Quality improvement project managers** will be responsible for being the subject matter experts for standardized quality performance measures, such as HEDIS®, and project management of the medical record reviews. In addition, the position will perform HEDIS®-related tasks, such as monitoring HEDIS® through Performance Improvement Projects (PIPs).
- **Quality improvement analysts** will manage medical record reviews and are the subject matter

experts for conducting ambulatory medical record review to assess the quality of care delivered and documented. The analysts also evaluate and review and analyze data for EPSDT reporting. The QI analysts will also develop PIPs, including participation in the statewide PIP.

- The **Quality improvement coordinator** will be responsible for organizing activities within the QI department. A major responsibility of the QI coordinator includes coordinating the QAPIC and Utilization Management Medical Committee (UMC).
- **Clinical HEDIS® practice advisors (CHPAs)** will be registered Nebraska nurses who visit high-volume providers to discuss HEDIS® criteria. During these visits, the CHPAs will conduct provider medical record abstraction. Through these efforts, the CHPAs will determine root cause or barriers prohibiting HEDIS® services from being captured in claims/encounter data, as well as educate providers on ways to capitalize on routine visits by completing well child checks, immunizations as applicable and preventive screenings during the member's appointment.
- **CommUnity advocates:** CommUnity advocates work with community partners to find innovative, community-based programs that use evidence-based practice guidelines to which we refer our members. CommUnity advocates connect with social service agencies to establish a contractual relationship through which track members referred to services for outcomes reporting. They also work with quality improvement teams to leverage community programs to support quality-related activities.

Policies and Procedures

WellCare QAPI infrastructure is supported by written policies and procedures that guide our implementation of all QAPI activities, including frequency of data analysis, performance measures, EQRO requirements, accreditation, medical record reviews, HEDIS reporting and HEDIS database maintenance. Detailed reports include data analysis and results regarding the effectiveness of the QAPI program and follow the requirements outlined in our policies and procedures, are presented to governance committees (described below) for review and feedback. WellCare's QAPI adheres to polices surrounding the QI program and provider involvement.

QUALITY PROGRAM'S INFRASTRUCTURE: COORDINATION WITH SUBCONTRACTORS AND CORPORATE ENTITIES

Oversight of Subcontractors

WellCare delegates certain operational functions to qualified subcontractors, including our pharmacy benefits manager and chart abstraction vendor. (WellCare manages behavioral health services internally.) While we do work with subcontractors, ***we retain oversight over all quality responsibilities***. We follow the NCQA Health Plan standards on delegation as it relates to QAPI functions. Our subcontractor oversight teams evaluate each delegate's capacity to perform any contracted activities prior to the delegation initiation, including reviewing the delegate's policies and procedures to make sure they follow our accreditation standards and are not in conflict with our policies. We perform an initial file review to determine their ability to perform the functions according to our standards and practices. Annually, we perform a file audit on all delegated entities to ensure the delegated entities continue to be in compliance with contractual, regulatory and accreditation requirements, with a special emphasis on quality requirements. When performance deviates from our established performance standards, subcontractors are required to implement corrective actions. WellCare monitors completion of corrective actions to ensure deficiencies have been successfully remediated.

Our QAPI committee structure includes a Delegation Oversight Committee (DOC) which has ultimate responsibility for all oversight activities for those functions we have delegated such as pharmacy. The DOC coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory and accreditation requirements. The DOC is chaired by the senior director of corporate audit and oversight and will report to the QAPIC at least quarterly. Additionally, our systems

allow for data from our subcontractors to be seamlessly integrated into our QAPI Program so analyses can inform improvement activities across the spectrum of all services.

Collaboration with our Corporate Entities

WellCare has established a corporate team structure to support data collection, data analysis, and reporting functions for all of its subsidiary plans. The multidisciplinary team, led by WellCare's Chief Medical Director of Quality, is composed of analysts, developers, data administrators, and informatics experts who know our systems, understand the data within the systems, and have the experience to report the data in a manner that supports the analytics required to effectively manage care for our Nebraska members. The various roles of the WellCare quality corporate support team include:

- The **Quality Analytics** department, which is responsible for analysis related to all aspects of quality, retrospective analysis and trend analysis from a quality improvement perspective. The department uses a variety of data sets, including NCQA certified quality-measure reporting software that calculates performance measures using a combination of administrative and clinical (chart review) data sources. Performance, including adherence to clinical practice guidelines, is compared against state and national benchmarks (when available) and past performance. Data can be analyzed at multiple levels including provider, provider type, and geographic areas. the This skilled group of individuals is comprised of a team that has decades of health care analytics reporting experience providing data retrieval, management, and mining, report writing and graphics (e.g. run charts and heat maps), and statistical analysis.
- The **Medical Economics** department, which is responsible for analysis related to all aspects of quality, predictive modeling, retrospective analysis, under- and overutilization, and trend analysis from a financial perspective. This team is able to pull data stored within our Data Management Solution to develop reports, studies, analyses and ad hoc requests using tools such as SAS® and Cognos. The team uses information available in standard claims fields including but not limited to CPT, diagnosis (primary, secondary, etc.), DRG, specialty type, provider Type, provider, facility, member, member Type, bill type, denials, appeals, and authorizations. The data allow us to analyze utilization rates such as number of days, admissions, visits, and length of stay; unit cost, including cost per visit and per day; per member per month costs by cost categories (inpatient, outpatient); and claims payments against state Medicaid and Medicare rates. The analyses are used to help us understand our operations in order to make ongoing improvements.
- The **Operational Reporting** team, which includes experienced developers who are adept at operationalizing key regulatory, quality, and performance reporting such as call center statistics, complaints, appeals, member retention, completion of health risk screenings, and pharmacy benefit manager performance. The primary focus of this group is to develop reports that are run automatically on a periodic (e.g., hourly, daily, weekly, monthly, quarterly, annually, or other) basis and are used either for regulatory purposes or for real-time monitoring of program elements.
- The **Advocacy and CommUnity-Based Programs** department maintains the technical systems to capture access and use of social services by members and their families at the transactional level. (Use of a HIPAA-compliant Business Associates Agreement allows for specific referrals and rigorous evaluation of outcomes.). In addition the team assembles community-based, public health data on which to identify health trends that could impact our membership. Using the social service referral data, we can identify potential gaps in social service availability to pilot community-based solutions for filling those gaps for our members, the families and the communities-at-large. The primary focus of this team is to create greater transparency of the social safety net and its positive impact on health outcomes.

Performance Improvement Committee: Ensuring Appropriate Accountability for Quality Assurance

WellCare uses a comprehensive QAPI committee structure to ensure participation of multiple voices into the process as well as structured and robust oversight of QAPI activities and the quality of our program as a whole.

WellCare of Nebraska Board of Directors

The WellCare of Nebraska Board of Directors (the Board) is the governing body of WellCare of Nebraska and has overall accountability and responsibility for the quality of care and services rendered to our members. The Board supports and has final authority over the general oversight and strategic direction of our QAPI Program. The Board provides strategic direction to the QAPI Program including the objective and systematic monitoring of the quality, appropriateness, accessibility, and availability of health care and services provided to our members. Its responsibilities include: ensuring that the QAPI Program is incorporated into WellCare's operations at all levels and has the resources necessary to achieve the highest quality outcomes for our members; reviewing and providing feedback on the activities of the QAPI Program; and, performing an annual review and approval of the QAPI Program Description, QAPI Work Plan and QAPI Annual Evaluation used to oversee the effectiveness of the QAPI Program and ensure members receive appropriate, cost-effective, high-quality care. The Board will delegate responsibility for QAPI activities including monitoring and evaluating outcomes, overall effectiveness of the QAPI Program, and initiating corrective action plans when appropriate to WellCare of Nebraska's QAPIC. The Board meets a minimum of quarterly to review and assess the QAPI Program.

Quality Assurance and Performance Improvement Committee (QAPIC)

The QAPIC is the centralized body responsible for integrating quality initiatives throughout the organization and overseeing the QAPI Program. The QAPIC will report directly to the Board.

Membership

Members of WellCare of Nebraska's executive leadership team will be members of the QAPIC and help ensure that the QAPI Program complies with NCQA and MLTC standards. In addition to our executive leadership, WellCare's QAPIC will include members, member representatives, providers, and other community stakeholders, so we can hear first-hand their experiences and ideas for ensuring continuous quality improvement and implementing QAPI strategies that will lead to improved health outcomes in Nebraska. Our QAPIC membership will include our: medical director (chairperson), behavioral health clinical director, quality management /performance and quality improvement coordinator, medical management coordinator, member services manager, provider services manager, family members/guardians of children or youth who are Medicaid members, adult Medicaid members, and network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives will have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations. WellCare will provide training, participation stipends, and reimbursement for travel, child care, or other reasonable participation costs for

QAPIC Membership

WellCare's QAPIC will include members, member representatives, providers, and other community stakeholders, so we can hear first-hand their experiences and ideas for ensuring continuous quality improvement and implementing QAPI strategies that will lead to improved health outcomes in Nebraska.

members or their family members. Participation stipends will only be provided if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization.

Responsibilities

Under the guidance of WellCare of Nebraska's medical director, the QAPIC will be responsible for the following activities: coordinating the quality monitoring and improvement activities outlined in our annual QAPI Program Description and the QAPI Work Plan; reviewing and approving WellCare's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC; reviewing the Cultural Competency Plan; requiring WellCare to study and evaluate issues that MLTC or the QAPIC may identify; establishing annual performance targets; reviewing and approving all member and provider surveys prior to their submission to MLTC; defining the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries; and annually, and as requested, provide data (with staff support from our medical director and quality management/ performance and quality improvement coordinator) to MLTC's Quality Committee. WellCare will also incorporate recommendations from all staff and QAPI committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.

Quality Assessment Performance Improvement (QAPI) Related Committees

WellCare's QAPIC will be supported by a number of WellCare of Nebraska committees as outlined in **Figure 2**, who will report, at least quarterly, to the QAPIC a summary of their QAPI-related work, recommendations, needs and activities.

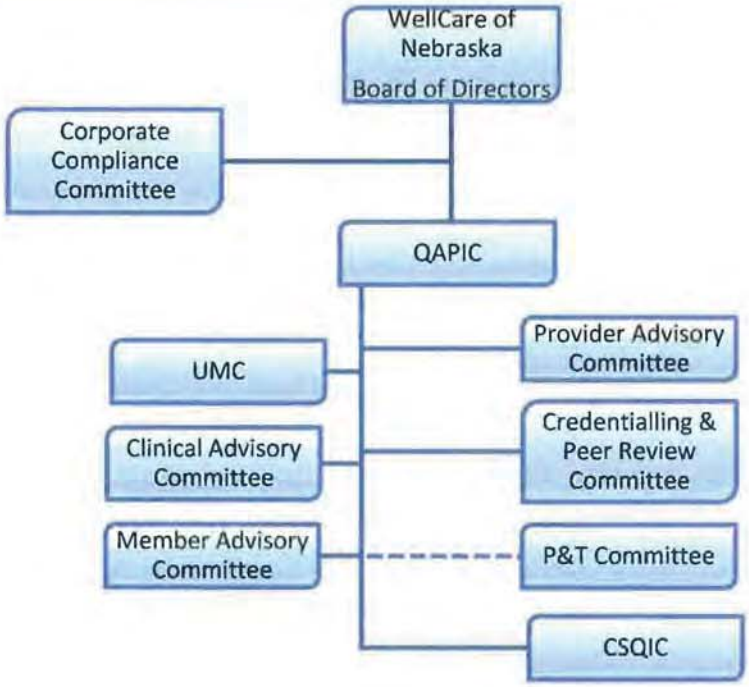
- **Clinical Advisory Committee:** WellCare will convene a Clinical Advisory Committee comprised of an expert panel of Nebraska-based clinicians representing a cross-section of providers in the fields of physical health, behavioral health and pharmacy to help us ensure members receive the right care, at the right time and in the right setting. Participants will be clinicians who care for children, adolescents and adults across a variety of ages and races/ethnicities and have an awareness of differences between rural and urban populations. These clinicians will help us improve quality of care and access to services to meet Nebraska's goals for Heritage Health.
- **Member Advisory Committee:** WellCare's Member Advisory Committee will be a forum for gathering feedback from members, member representatives, providers, and community advocates that reflect the geographic, cultural and racial diversity of WellCare's population and the communities we serve. Among other responsibilities, committee members will be invited to discuss the quality of their customer experiences with WellCare and their health care providers. Committee members will help identify root causes of barriers to receiving care as well as strategies for overcoming barriers.
- **Provider Advisory Committee:** WellCare will establish a Nebraska Provider Advisory Committee (PAC) with representation from the major provider organizations in Nebraska, individual providers, behavioral health, pharmacy providers, hospitals, and providers who primarily serve individuals with disabilities. It is our intent to work collaboratively with our PAC and established provider organizations as we create network development and management strategies and procedures.
- **Utilization Management Committee** WellCare's Utilization Management Committee (UMC) will be a subcommittee of the QAPIC and will be responsible for promoting the delivery of quality clinical services for our members and assuring efficient and appropriate utilization of health care services. Our UMC, chaired by our local medical director, will be responsible for the day-to-day operation and organization of the UM function including standards or practice, practice guidelines, prior authorization rules, review criteria (including the consistent application of), health care trends, and cost of care.
- **Corporate Compliance Committee:** WellCare of Nebraska's Corporate Compliance Committee, a committee of the WellCare of Nebraska Board of Directors, will assist the Board in overseeing

WellCare of Nebraska's regulatory compliance program, policies and procedures, including compliance with federal and state laws, rules and regulations, and compliance with WellCare's code of conduct and business ethics and related policies by employees, officers, directors and other agents of, and those providing services for WellCare of Nebraska.

- **Credentialing and Peer Review Committee:** The QAPIC will delegate credentialing and re-credentialing oversight and approval authority to the Credentialing and Peer Review Committee. The committee is chaired the medical director and includes voting provider representatives as well as cross-departmental representation from WellCare of Nebraska and corporate entities. This committee is also responsible for peer review of provider quality of care/service and conduct issues.
- **Customer Service Quality Improvement Committee (CSQIC):** The Customer Service Quality Improvement Committee (CSQIC) functions as a multidisciplinary task force to identify opportunities for improvement in customer service. The CSQIC reviews data on call metrics such as average speed of answer, abandonment rates and first call resolutions for both member and provider calls. In addition to the customer service call metrics, the CSQIC also reviews data relevant to member and provider complaints and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, the process is compliant with regulatory standards and issues are referred for system response through the QAPI process. The focus of the CSQIC is on the systemic analysis of access and quality of service provided to members.
- **Pharmacy and Therapeutics Committee (P&T):** The Pharmacy and Therapeutics (P&T) Committee will promote the appropriate use of high quality and cost-effective pharmaceuticals for members and ensure compliance with appropriate standards and state and federal regulations, including coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and the Nebraska Medicaid preferred drug list (PDL).

Figure 2

QAPI Related Committees



SUPPORTING MLTC'S QUALITY STRATEGY

WellCare will support and comply with the MLTC Quality Strategy and seek to improve the health and wellness of Medicaid clients by increasing their access to comprehensive health services in a cost-effective manner. WellCare will partner with MLTC to implement strategies such as reducing non-emergent use of the emergency department (ED) through increased access to care, improving birth outcomes through prenatal, postnatal, and inter-pregnancy care, improving outcomes through coordination and integration of prevention-focused physical and behavioral health services delivered in community-based settings, and improving food security. Through participation and active engagement on MLTC's QM Committee, participation in statewide PIP efforts, comprehensive and consistent reporting of Heritage Health performance measures, and implementation of our proposed valued added services and programs, we are confident we can bring our experience and record of partnership, collaboration, and innovation to help MLTC meet the goals of its Quality Strategy.

Participation on MLTC Quality Management Committee and Sub-Committees

WellCare of Nebraska, through representation by our medical director will participate on the MLTC Quality Management Committee. Our medical director, and as appropriate, our behavioral health clinical director and our quality management/ performance and quality improvement coordinator, will participate on any associated subcommittees as requested by MLTC.

Participation on Joint PIP(s)

WellCare will support MLTC's efforts and initiatives to improve health outcomes and quality of life for all Heritage Health Members through collaboration and alignment on joint PIP(s) with MLTC and other system partners. Our clinical and executive leadership will actively participate and support collaborative working groups that include MLTC and MCO representatives to ensure alignment across interventions, data collection and analysis, and evaluation.

Alignment of WellCare QAPI Program with MLTC Quality Strategy

Our QAPI Work Plan will include key focus areas from MLTC's Quality Strategy. We will also work collaboratively with MLTC staff to address and ensure implementation of all elements of the MLTC Quality Strategy and our QAPI Program, including, but not limited to: monitoring and evaluating our service delivery system and provider network and QAPI processes; implementing action plans and activities to correct deficiencies or increase the quality of care provided to members; initiating PIPs to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider profiling, utilization management reviews, etc.; monitoring our compliance with federal, state, and MLTC requirements; ensuring our executive and management staff participate in QAPI processes; ensuring that the development and implementation of QAPI activities include provider participation and information provided by members, their families and guardians; identifying WellCare of Nebraska's best practices, lessons learned, and other QAPI findings.

Performance Reporting

Consistent with the reporting requirements described Section IV.M.6 and Attachment 7 of the Nebraska Heritage Health RFP, WellCare will report Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required by CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, ACA Adult Quality Measures as defined by CMS, and any other measures as determined by MLTC. WellCare will report results of measuring and assessing outcomes and quality and will incorporate these performance indicators into its PIPs. To the extent possible, WellCare will report results publicly on our website immediately after being accepted by the QAPIC and approved by MLTC.

Value Added Services

WellCare proposes a suite of value added services that are tailored to specifically address Nebraska's

population-specific needs and health outcome goals. We believe these value added services will deliver meaningful, lasting improvements for our members thereby delivering value to our Providers and MLTC. WellCare will collect data annually to identify its progress towards success as well as opportunities for ongoing process and quality improvement. As determined through our evaluation efforts, WellCare will consider additions, deletions, or modifications to our value-added services during the contract period to further MLTC's Quality Strategy. We will submit such changes for approval to MLTC a minimum of 45 calendar days prior to implementation.

SELECTING FOCUS AREAS

Among each of WellCare's affiliate health plans, our QAPI Programs are designed to be comprehensive, systematic, and continuous quality assessment and improvement programs that use an internal analysis process to select areas of focus. In alignment with MLTC's Quality Strategy, WellCare's Nebraska-based and corporate QAPI-related teams, including Medical Economics, Medical Informatics, and our Advocacy and CommUnity-Based Programs department, will analyze available internal and external data to identify QAPI focus areas. Data sources will include, at a minimum, the following: claims and encounters, authorizations, call center statistics, appeals and grievances, medical record reviews, care plans, HEDIS measures, CAHPS measures, case management audits, disease management audits, and provider satisfaction surveys. Consistent with our practice in other states, WellCare will also utilize census, environmental, economic, social and clinical/health care data for the community and combines it with data regarding our membership.

WellCare uses the Plan-Do-Study-Act (PDSA) method of continuous quality improvement throughout the organization. Under the PDSA approach multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurement occur to ensure progress toward established goals. Continuous Quality Improvement (CQI) processes will be used to develop the QAPI Program Description, Work Plan and Program Evaluation.

We will incorporate recommendations from all staff and WellCare committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation. Once approved by our QAPIC, WellCare will annual submit our QAPI Program Description, Work Plan and Program Evaluation to MLTC.

WellCare of Nebraska will also collaborate with MLTC's contracted EQRO to develop studies, surveys, and other analytic activities to assess the quality of care and services provided to members and to identify opportunities for improvement. To facilitate this process, WellCare of Nebraska will supply data, as requested by MLTC or its EQRO.

PROPOSED QAPI WORK PLAN AND PLANNED INITIATIVES

See **Attachment 68_Proposed QAPI Work Plan** for a copy of WellCare's proposed QAPI Work Plan and planned initiatives.

WellCare of Nebraska Executive Summary – 2017 QI Work Plan

WellCare of Nebraska quality improvement activities and performance measures will be reviewed, evaluated, and revised annually as outlined in the 2017 QI Program Description. This evaluation includes trended data (where available) and analyses of impact on clinical care and service delivery. Strengths, weaknesses, barriers and opportunities for improvement will be considered during the process to assess the overall effectiveness of the Quality program in improving care and services provided to WellCare members.

The [insert QI staff] , and other applicable departments, will annually perform the evaluation of all work plan metrics and compile an annual QI Evaluation document of the findings.

For Example: Changes in the work plan from 2016 to 2017:

FOR EXAMPLE:

- The following sections have been added in to 2016 plan: Behavioral Health, Timely Access for Appointments, Community Engagement, Adequacy was expanded.

Key focus areas in the 2017 QI work plan:

FOR EXAMPLE:

- Member and Provider Satisfaction (CAHPS) interventions
- HEDIS interventions for various measures
- Timely Access for Appointment metrics and monitoring
- Appeals and Grievance data will be included once available
- Patient Safety initiatives: Quality of Care, Hospital Patient Safety...
- High Risk Pregnancy Program goals and interventions
- Process Improvement Projects (PIPs)

Behavioral Health measures and interventions
Utilization Review, Case and Disease Management

UMAC Committee Approval Date:
QI Committee Approval Date:
BOD Committee Approval Date:

MUST HAVE COMMITTEE APPROVALS THROUGHOUT THE YEAR AS CHANGES ARE MADE TO THE WORKPLAN

Attachment 68_Proposed QAPI Work Plan

MCO Name: WellCare of Nebraska Inc.
Report Run Date:
Report Period From: Jan 2017
Report Period To: Dec 2017

DRAFT

ALL GOALS MUST BE MEASUREABLE, AND UPDATED ANNUALLY

Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	Report
I. NETWORK ADEQUACY/AVAILABILITY AND APPOINTMENT ACCESS				
Activity Name: Emergent Behavioral Health Appointment Access **Objective:** Ensure members have adequate emergent appointment access to behavioral health providers. **Goals:** **- At minimum, referred to services within one hour generally and within two hours in designated rural areas** **Monitoring:** QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR***	Director, Network Development/Behavioral Health	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Behavioral Health Network Availability **Objective:** Ensure that members have adequate numbers of PCPs in urban and rural locations. **Goal:** **- At minimum, behavioral health inpatient and residential service providers must have sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural frontier areas.** **- At minimum, behavioral health outpatient assessment and treatment providers within** **- 30 miles of members' personal residences in urban areas** **- two providers within 45 miles of members' personal residences in rural counties** **- two providers within 60 miles of members' personal residences in frontier counties** **Monitoring:** QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR***	Director, Network Development/Behavioral Health	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: PCP Appointment Access **Objective:** Ensure members have adequate appointment access to PCPs for routine and urgent care. **Goals: Appointment Times:** **- Non-urgent preventive care must be available within 4 weeks** **- Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation** **Monitoring:** QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR***	Director, Provider Relations	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

	Behavioral Health Providers		
	Within 1 hour	Within 2 hours	Non-life Threatening Emergency (within
1st Quarter	-	-	-
2nd Quarter	-	-	-
3rd Quarter	-	-	-
4th Quarter			

	PCP	
	Non-Urgent Sick (within 72 hrs.)	Non-Urgent Preventive (within 4 weeks)
1st Quarter	-	-
2nd Quarter	-	-
3rd Quarter	-	-

			4th Quarter		
Activity Name: PCP Network Availability **Objective:** Ensure that members have adequate numbers of PCPs in urban and rural locations. **Goal:** **- At minimum, two PCPs within 30 miles of the personal residence of members in urban counties** **- At minimum, one PCP within 45 miles of the personal residence of members in rural counties** **- At minimum, one PCP within 60 miles of the personal residences of members in frontier counties** **Monitoring:** QIC Quarterly ☐ ***PREVIOUSLY IDENTIFIED ISSUES CHECK*** **THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Director, Network Development	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**		
Activity Name: Pharmacy Network Availability **Objective:** Ensure members have adequate availability of pharmacy services. **Goal:** **- In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences** **- In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences** **- In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences** **Monitoring:** QIC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Director, Provider Relations	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**		
Activity Name: Specialty Care Appointment Availability **Objective:** Ensure members have adequate availability of specialty care providers. **Goals:** **- At minimum, within 30 calendar days of referral for high volume specialty care.** **- At minimum, consultations within one month of referral or as clinically indicated for all other specialties.** **High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.** **Monitoring:** QIC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Director, Provider Relations	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**		
Activity Name: Laboratory and X-Ray Services Appointment Availability **Objective:** Ensure members have adequate appointment access to laboratory and x-ray. **Goals:**	Director, Network Development	QUARTERLY	**1st Quarter:**		

Goals: - At minimum, within 3 weeks for routine appointments -At minimum, within 48 hours (or as clinically indicated) for urgent care Monitoring: QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Maternity Care Appointment Availability **Objective:** Ensure members have adequate numbers of providers for maternity health care. **Goal:** - At minimum, within 14 calendar days of request during the first trimester - within 7 calendar days during the second trimester - within 3 calendar days during the third trimester - within 3 calendar days of identification of high-risk pregnancies **Monitoring:** QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: PCP Practice Hours Availability **Objective:** Ensure providers have an adequate number of office hours for our members. **Goals:** - PCPs who have a one-physician practice must have office hours of at least 20 hours per week - PCPs with two or more physicians must have office hours of at least 30 hours per week **Monitoring:** QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: PCP After-Hours Phone Access **Objective:** Ensure members have adequate after-hours phone access to PCPs. **Goal:** • Achieve a PCP and Pediatrician after-hours phone availability compliance rate of 95%. **Monitoring:** QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter: 1st Quarter 2nd Quarter 3rd Quarter 4th Quarter	PCP After-Hours Call Returned within 30 - - -
Activity Name: Family Planning Services Appointment Availability **Objective:** Ensure members have adequate availability for family planning services. **Goals:** - At minimum, within 7 calendar days.	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter:	

Monitoring: Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			3rd Quarter: 4th Quarter:	
Activity Name: Specialty Care Network Availability **Objective:** Ensure members have adequate availability of specialty care providers. **Goals:** **- At minimum, contract with one high volume specialist within 90 miles of personal residences of members.** **High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.** **Monitoring:** QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Emergency Services Appointment Availability **Objective:** Ensure members have adequate availability of emergency service providers. **Goals:** **- At minimum, must be available immediately upon presentation at the service delivery site 24 hours a day, 7 days a week.** **Monitoring:** QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Urgent Care Appointment Availability **Objective:** Ensure members have adequate availability of urgent care services **Goals:** **- At minimum, must be available same day and be provided by the PCP or as arranged by the MCO.** **Monitoring:** QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Long Term Care Access and Network Adequacy **Objective:** Ensure members have adequate availability to long term care providers in urban and rural areas. **Goals:** **- Meet or exceed provider network standards.** **Monitoring:** QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Director, Network Development	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
II. CLINICAL PRACTICE GUIDELINE DEVELOPMENT AND REVIEW				
Activity Name: Behavioral Health Clinical Practice Guidelines **Objective:** To assist practitioners and members make clinical decisions regarding appropriate care for behavioral health conditions. **Goal:** • **Develop, adopt, review, and distribute at least two clinical practice guidelines for behavioral health conditions pertaining to the Plan's membership to practitioners and members.** **Monitoring:** QIC every 2 years or as updated □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Sonya Coates Colangelo/Clinical Policy Research Writer, Sr	Every 2 years	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Chronic Condition Clinical Practice Guidelines **Objective:** To assist practitioners and members in making clinical decisions regarding appropriate care for chronic medical conditions. **Goal:** Develop, adopt, review, and distribute at least two clinical practice guidelines for chronlc health conditions pertaining to the Plan's membership to practitioners and members. **Monitoring:** QIC every 2 years or as updated □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Sonya Coates Colangelo/Clinical Policy Research Writer, Sr	Every 2 years	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Preventive Health Guidelines **Objective:** To assist practitioners and members in the early detection/prevention of illness and disease.	Sonya Coates Colangelo/Clinical Policy Research Writer, Sr	Annually	**1st Quarter:**	

Goal: • **Develop, adopt, review, and distribute preventive health guidelines to practitioners and members.** Monitoring: QIC Annually ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**2nd Quarter:**	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Long Term Care Clinical Practice Guidelines **Objective: To assist practitioners and members make clinical decisions regarding appropriate care for long term care health conditions.** **Goal:** • **Develop, adopt, review, and distribute at least two clinical practice guidelines for long term care conditions pertaining to the Plan's membership to practitioners and members.** Monitoring: QIC Annually **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Sonya Coates Colangelo/Clinical Policy Research Writer, Sr	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
III. MEMBER AND PROVIDER SATISFACTION				
A. Experience of Care: CAHPS				
Activity Name: Overall Rating of Health Care (CPA) **Objective:** To improve the percentage of members reporting satisfaction with their overall rating of health care. **Goals:** ***Implement activities to improve the percentage of members reporting satisfaction with their overall rating of health care** ***Achieve results at the 50th percentile or better** ***Monitor member grievances regarding health care** **Monitoring:** QIC Annually □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Overall Rating of Health Plan (CPA) **Objective:** To improve the percentage of members reporting satisfaction with their overall rating of the health plan. **Goals:** **• Implement activities to improve the percentage of members reporting satisfaction with their overall rating of health plan** ***Monitor member grievances regarding the health plan.** ***Achieve results at the 50th percentile or better** **Monitoring:** QIC Annually □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Rating of Personal Doctor (CPA) **Objective:** To improve the percentage of members reporting satisfaction with their personal doctor.	Quality Improvement	Annually	**1st Quarter:**	

Goals: *Implement activities to improve the percentage of members reporting satisfaction with their personal doctor. *Monitor member grievances regarding personal doctors *Achieve results at the 50th percentile or better Monitoring: QIC Annually □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Rating of Specialist (CPA) Objective: To improve the percentage of members reporting satisfaction with their specialist seen most often. Goals: *Implement activities to improve the percentage of members reporting satisfaction with their specialist seen most often *Monitor member grievances regarding specialists *Achieve results at the 50th percentile or better Monitoring: QIC Annually □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement	Annually	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Getting Care Quickly (CPA) Objective: To improve the percentage of members reporting satisfaction with getting care quickly. Goals: *Implement activities to improve the percentage of members reporting satisfaction with getting care quickly. *Monitor member grievances regarding getting care quickly. *Achieve results at the 50th percentile or better Monitoring: QIC Annually □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement	Annually	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Getting Needed Care (CPA) Objective: To improve the percentage of members reporting satisfaction with getting needed care. Goals: *Implement activities to improve the percentage of members' satisfaction with getting needed care. *Monitor member grievances regarding getting needed care.	Quality Improvement	Annually	1st Quarter: 2nd Quarter:	

Achieve results at the 50th percentile or better** **Monitoring:** QIC Annually □ ***PREVIOUSLY IDENTIFIED ISSUES **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**3rd Quarter:**	
			4th Quarter:	
Activity Name: How Well Doctors Communicate (CPA) **Objective:** To improve the percentage of members reporting satisfaction with how well doctors communicate. **Goals:** *** Implement activities to improve the percentage of members reporting satisfaction with how well doctors communicate.** ***Achieve results at the 50th percentile or better** **Monitoring:** QIC Annually □ ***PREVIOUSLY IDENTIFIED ISSUE*** **S CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
B. Member Appeals and Grievances				
Activity Name: Member Appeals **Objective:** To monitor and identify areas of member appeals and implement action as necessary to improve member satisfaction. **Goals:** ***Report the number, type, and resolution of member appeals.** **• Resolve 95% of appeals within compliance and accreditation timeframes** **• Identify trends or problem areas and implement activities to improve member satisfaction.** **Monitoring:** QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Appeals	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Member Grievances **Objective:** To monitor and identify areas of member dissatisfaction and implement action as necessary to improve member satisfaction. **Goals:**	Grievances	QUARTERLY	**1st Quarter:**	

*Report the number, type, and resolution of member grievances. • Resolve 95% of grievances within compliance. • Identify trends or problem areas and implement activities to improve member satisfaction. Monitoring: QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			2nd Quarter: 3rd Quarter: 4th Quarter:	
C. Provider Appeals and Grievances				
Activity Name: Provider Appeals **Objective:** To monitor and identify areas of provider appeals and implement action as necessary to improve provider satisfaction. **Goals:** *Report the number, type, and resolution of provider appeals. • Resolve 95% of appeals within compliance and accreditation timeframes • Identify trends or problem areas and implement activities to improve provider satisfaction. Monitoring: QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Appeals	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Provider Grievances **Objective:** To monitor and identify areas of provider dissatisfaction and implement action as necessary to improve provider satisfaction. **Goals:** *Report the number, type, and resolution of provider grievances. • Resolve 95% of grievances within compliance. • Identify trends or problem areas and implement activities to improve provider satisfaction. Monitoring: QIC Quarterly □ *PREVIOUSLY IDENTIFIED ISSUES* CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Grievances	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Provider Satisfaction Survey **Objective:** Access the level of provider satisfaction with the Plan as measured by the Plan's provider satisfaction survey	Quality Improvement Operations	Annually	1st Quarter:	

as measured by the Plan's provider satisfaction survey. **Goals:** **• Implement interventions to improve provider satisfaction ratings.** **• Assess provider satisfaction with the Plan.** **• Monitor provider grievances.** **Monitoring:** UMAC and QIC Annually **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary				
IV. CREDENTIALING							
Activity Name: Allied Health Provider Initial Credentialing and Recredentialing **Objective:** To evaluate allied health providers against the Plan's credentialing process and procedures to provide care for members. **Goals:** • **Credential 90% of allied providers with clean files within 30 days.** • **Credential 100% or allied providers with clean files within 45 days.** **Monitoring**: Credentialing Committee Minutes to QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**				
				Clean Files within 20 days (%)	Numerator/ Denominator	Clean Files within 30 days (%)	Numerator/ Denominator
			1st Quarter:				
			2nd Quarter:				
			3rd Quarter:				
			4th Quarter:				
Activity Name: Ancillary Provider Initial Credentialing and Recredentialing **Objective:** To evaluate ancillary providers against the Plan's credentialing process and procedures to provide care for members. **Goals:** • **Credential 90% of ancillary providers with clean files within 20 days.** • **Credential 100% or ancillary providers with clean files within 30 days.** **Monitoring:** Credentialing Committee Minutes to QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**				
				Clean Files within 20 days (%)	Numerator/ Denominator	Clean Files within 30 days (%)	Numerator/ Denominator
			1st Quarter				
			2nd Quarter				
			3rd Quarter				
			4th Quarter				
Activity Name: PCP Initial Credentialing and Recredentialing **Objective:** To evaluate PCP against the Plan's credentialing process and procedures to provide care for members	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:** **2nd Quarter:**				

process and procedures to provide care for members. **Goal:** **• Credential 90% of practitioners with clean files within 20 days.** **• Credential 100% or practitioners with clean files within 30 days.** **Monitoring:** Credentialing Committee Minutes to QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**3rd Quarter:** **4th Quarter:** Clean Files within 20 days (%) / Numerator/ Denominator / Clean Files within 30 days (%) / Numerator/ Denominator 1st Quarter 2nd Quarter 3rd Quarter 4th Quarter
Activity Name: Specialist Practitioner Initial Credentialing and Recredentialing **Objective:** To evaluate Specialty Care practitioners against the Plan's credentialing process and procedures to provide care for members. **Goal:** **• Credential 90% of practitioners with clean files within 20 days.** **• Credential 100% or practitioners with clean files within 30 days.** **Monitoring:** Credentialing Committee Minutes to QIC Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:** Clean Files within 20 days (%) / Numerator/ Denominator / Clean Files within 30 days (%) / Numerator/ Denominator 1st Quarter 2nd Quarter 3rd Quarter 4th Quarter
Activity Name: Long Term Care Provider Initial Credentialing and Recredentialing **Objective:** To evaluate Long Term Care Provider practitioners against the Plan's credentialing process and procedures to provide care for members. **Goal:** **• Credential 90% of practitioners with clean files within 30 days.** **• Credential 100% or practitioners with clean files within 45 days.** **Monitoring:** Credentialing Committee Minutes to QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:** Clean Files within 20 days (%) / Numerator/ Denominator / Clean Files within 30 days (%) / Numerator/ Denominator 1st Quarter 2nd Quarter 3rd Quarter 4th Quarter

Activity Name: Behavioral Health Provider Initial Credentialing and Recredentialing **Objective:** To evaluate Behavioral Health Provider practitioners against the Plan's credentialing process and procedures to provide care for members. **Goal:** • **Credential 90% of practitioners with clean files within 30 days.** • **Credential 100% or practitioners with clean files within 45 days.** **Monitoring:** Credentialing Committee Minutes to QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Taraka Busch/Director-Credentialing	QUARTERLY	**1st Quarter:**				
			2nd Quarter:				
			3rd Quarter:				
			4th Quarter:				
				Clean Files within 20 days (%)	Numerator/ Denominator	Clean Files within 30 days (%)	Numerator/ Denominator
			1st Quarter				
			2nd Quarter				
			3rd Quarter				
			4th Quarter				

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
V. CONTINUITY AND COORDINATION OF CARE (NCQA ACCREDITATION ACTIVITIES) **LIST THE SPECIFIC DATA POINTS THAT YOU ARE USING TO MEET QI 10 AND QI 11**				
A. Coordination of Care Medical				
Activity Name: Compliance with Medical Record Documentation Standards **Objective:** To improve the quality of care delivered to members by assessing PCPs, OB/GYNs, and behavioral health providers' compliance with the Plan's medical record documentation standards. **Goals:** **• Implement activities to improve the PCP, OB/GYN, and behavioral health practitioner compliance with medical record documentation standards.** **• Assess provider compliance with medical record documentation standards** **Monitoring:** UMAC and QIC and Annually □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Coordination of Care Between Medical and Behavioral Health **Objective:** To monitor and take action as necessary, to improve coordination between medical care and behavioral healthcare. **Goals:** **• Implement activities to improve the coordination of medical care and behavioral healthcare.** **• Annually collect data regarding exchange of information.** **• Annually collect data regarding appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.** **• Annually collect data regarding appropriate uses of psychopharmacological medications.**	Quality Improvement Behavioral Health Corporate	Annually	**1st Quarter:** **2nd Quarter:**	

• Annually collect data regarding management of treatment access and follow-up for members with coexisting medical and behavioral disorders. • Annually collect data regarding primary or secondary preventive behavioral healthcare program implementation. **Monitoring:** UMAC and QIC and Annually □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			3rd Quarter: 4th Quarter:	
Activity Name: Coordination of Care Between Medical and Long Term Care Services **Objective:** To monitor and take action as necessary, to improve coordination between medical care and long term care services healthcare. **Goals:** • Implement activities to improve the coordination of medical care and long term healthcare. • Annually collect data regarding exchange of information. • Annually collect data regarding appropriate diagnosis, treatment and referral of long term care services in primary care. • Annually collect data regarding management of treatment access and follow-up for members with long term care needs **Monitoring:** UMAC and QIC and Annually □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement Long Term Care - Corp/Market	Annually	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
VI. PERFORMANCE MEASUREMENT WITH CLINICAL PRACTICE GUIDELINES LIST THE SPECIFIC DATA POINTS THAT YOU ARE USING TO MEET QI 9D				
Activity Name: Flu Vaccincations for Adults Age 18 And Older (FVA) **Objective:** To improve the percentage of enrolees who received a flu vaccination. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Screening for Clinical Depression and Follow-Up Plan (CDF) **Objective:** To improve the percentage of enrollees age 18 and older screened for clinical depression using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	BH/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	
Activity Name: PC-01: Elective Delivery (PC01) **Objective:** To improve the percentage of Medicaid and CHIP enrolled women with elective vagnial deliveries or elective cesarean sections at ≥ 37 weeks and < 39 weeks of gestation completed. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	

PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			4th Quarter:	
Activity Name: PC-03: Antenatal Steroids (PC03) **Objective:** To improve the percentage of Medicaid and CHIP enrolled women at risk of preterm delivery at ≥ 24 and < 32 weeks gestation that received antenatal steroids prior to delivering preterm newborns. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarter;y ☐ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	CM/Quality Improvement	Quarterly	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Medical Assistance with Smoking and Tobacco Use Cessation (MSC) **Objective:** To improve the rolling average percentage of Medicaid enrollees age 18 anfd older who are current smokers or tobacco users and who received medical assistance with smoking and tobacco use cessation during the measurement year. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly ☐ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	CM/Quality Improvement	Quarterly	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Adherence to Antipsychotics for Individuals with Schizophrenia (SAA) **Objective:** To improve the percentage of Medicaid enrollees ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly ☐ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	BH/Quality Improvement	Quarterly	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (<9.0%) (HPC) **Objective:** To improve the percentage of Medicaid enrollees	CM/Quality Improvement	Quarterly	1st Quarter:	

Objective: To improve the percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin Aic in poor control (>9.0%). **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**2nd Quarter:** **3rd Quarter:** **4th Quarter:**
Activity Name: PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01) **Objective:** To improve the numbr of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees age 18 and older. **Goal: CMS Adult Core Set 75th percentile based on current rates** Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**
Activity Name: PQI 08: Heart Failure Admission Rate (PQI08) **Objective:** To improve the number of inpatient hospital admissions for heart failure per 100,000 enrollee months for Medicaid enrollees age 18 and older. **Goal: CMS Adult Core Set 75th percentile based on current rates** Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**
Activity Name: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05) **Objective:** To improve the number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for Medicaid enrollees age 40 and older.	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:**

Goal: CMS Adult Core Set 75th percentile based on current rates **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**3rd Quarter:** **4th Quarter:**	
Activity Name: PQI 15: Asthma in Younger Adults Admission Rate (PQI15) **Objective:** To improve the number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees ages 18 to 39. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Plan All-Cause Readmission (PCR) **Objective:** To improve the number of acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days for Medicaid enrollees age 18 and older. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: HIV Viral Load Suppression (HVL) **Objective:** To improve the percentage of Medicaid enrollees age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

Activity Name: Annual Monitoring for Patients on Persistent Medications (MPM) **Objective:** To improve the percentage of Medicaid enrollees age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care(CTR) **Objective:** To improve the percentage of discharges from an inpatient facility (e.g. hospital inpatient or observation, skilled nuring facility, or rehabilitation facility) to home or any other site of care for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge, among Medicaid enrollees age 18 and older. **Goal: CMS Adult Core Set 75th percentile based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Immunizations for Adolescents (IMA) **Objective:** To improve the percentage of adolescent 13 years old who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diptheria toxoids vaccine (Td) by their 13th birthday. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates**	Quality Improvement	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	

Monitoring: Annually □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**4th Quarter:**	
Activity Name: Developmental Screening in the First Three Years of Life (DEV) **Objective:** To improve the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Human Papilomavirus Vaccine for Female Adolescents (HPV) **Objective:** To improve the percentageof female adolescent 13 years old who had three doses of human papillomavirus (HPV) vaccine by their 13th birthday. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Pediatric Central Line-Associated Bloodstream Infections - Neonatal Intensive Care Unit and Pediactric Intensive Care Unit (CLABSI) **Objective:** To improve the percentage of central line-associated bloodstream infections (CLABSI) in pediatric and neonatal intensive care units (ICU). **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

Activity Name: PC-02 Cesarean Section (PC02) **Objective:** To determine the percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section and to improve guidelines and initiatives. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarerlty **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Live Births Weighing Less Than 2,500 Grams (LBW) **Objective:** To determine the percentage of live births that weighed less than 2,500 grams in the state during the reporting period. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Frequency of Ongoing Prenatal Care (FPC) **Objective:** To improve the number of live births that had the following number of expected prenatal visits: <21 percent of expected visits 21 percent-40 percent of expected visits 41 percent-60 percent of expected visits 61 percent-80 percent of expected visits ≥ 80 percent of expected visits **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) **Objective:** To improve the percentage of women, regardless of	BH/Quality Improvement	Quarterly	**1st Quarter:**	

age, who gave birth during a 12-month period seen at least once for prenatal who received a behaviorial health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA) **Objective:** To improve the percentage of patient visits for enrollees ages 6 to 17 with a diagnosis of major depressive disorder with an assessment for suicide risk. **Goal: CMS Child Core Set 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	BH/Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Ambulatory Care - Emergency Department (ED) Visits (AMB) **Objective:** To improve the rate of emergency department (ED) visits per 1,000 enrollee months among children up to the age of 19. **Goal: CMS Child Core Set 75th percentile based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM/UM Department	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Race/Ethnicity Diversity of Membership **Objective:** To determine and monitor race/ethnicity diversity rates and to improve the guidelines and initiatives. **Goal: NCQA 75th percentile HEDIS based on current rates**	Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:**	

Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**3rd Quarter:** **4th Quarter:**	
Activity Name: Antibiotic Utilization **Objective:** To monitor data on outpatient utilization of antibiotic prescriptions including: - Total number of antibiotic prescriptions - Average number of antibiotic prescriptions per member per year (PMPY) - Total days supplied for all antibiotic prescriptions - Average number of prescriptions PMPY for antibiotics of concern - Percentage of antibiotics of concern for all antibiotic prescriptions - Average number of antibiotics PMPY reported by drug class: For selected antibiotics of concern/For all other antibiotics **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Use of Appropriate Medications for People With Asthma (MMA) **Objective:** To improve the percentage of members with asthma 5-21 years of age who were prescribed appropriate asthma medication. **Goals: CMS Child Core Set 75th percentile based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**		QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Chlamydia Screening in Women (CHL) **Objective:** To improve the percentage of women 16-20 years of age who were identified as sexually active and who had at least	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:**	

one test for chlamydia during the measurement year. **Goal: CMS Child Core Set 75th percentile based on current rates** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**2nd Quarter:**	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
VII. PATIENT SAFETY INITIATIVES (Insert your market specific patient safety initiative activities in this section)				
Activity Name: Quality of Care (QOC) Issues **Objective:** To ensure the safety of the membership by investigating, resolving, and implementing provider corrective action as appropriate in instances regarding quality of care issues. **Goals:** • Monitor the number of QOC cases received for investigation, cases resolved, and implemented provider corrective action. • Monitor QOC cases by provider and diagnosis to identify trends and implement activities to decrease trends as appropriate. **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement and Long Term Care	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Quality of Practitioner Office Sites **Objective:** To ensure the quality, safety and accessibility of office sites where care is delivered. **Goals:** • Monitor the number of member grievances regarding the quality of practitioner office sites. • Implement corrective action as necessary to improve the quality, safety, and accessibility of practitioner office sites. **Monitoring: Quarterly** □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement and Long Term Care	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

Activity Name: Critical Incidents **Objective:** To ensure the safety of the membership by investigating, resolving, and implementing provider corrective action as appropriate in instances regarding Critical Incidents **Goals:** • **Monitor the number of Critical Incidents received for investigation, cases resolved, and implemented provider corrective action.** • **Monitor Critical Incidents to identify trends and implement activities to decrease trends as appropriate.** **Monitoring:** Daily **Reporting: Quarterly** □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Quality Improvement and Long Term Care	DAILY QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Provider Preventable Conditions **Objective:** To ensure providers are not reimbursed for provider preventable conditions. **Goals:** • Monitor the number of provider preventable conditions. • Implement corrective action as necessary **Monitoring: Quarterly** □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	Brian Pogue/Senior Director-Claims	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary
VIII. OPERATIONAL SERVICE PERFORMANCE			
Activity Name: Behavioral Health Services Call Stats **Objective:** To improve the quality of service delivered to members calling into the Behavioral Health Services Hotline. **Goals:** • Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system. • Achieve an AR of 7% or less. • Monitor the number of calls received by the hotline. • No incoming calls receive a busy signal. • At least 80% of calls are answered by staff within 30 seconds. • Achieve an average hold time of two minutes or less. • Monitor the number of calls immediately connected to the local Suicide Hotline or other Crisis Response System. • Monitor the number of calls requiring translation services. **Monitoring:** Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Behavioral Health	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**

Metric	1st Q	2ndQ	3rd Q	4thQ
% calls answered by 4th ring				
AR %				
ASA in seconds				
# calls received				
% calls received busy signal				
% calls answered by staff w/in 30 sec				
Average call length				
Average hold time				
# calls connected to suicide hotline				

			# calls requiring translation service				
Activity Name: Claims Payment **Objective:** To improve the quality of claims payment processes. **Goals: Achieve a financial accuracy rate (FAR) of 99.2%** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Brian Pogue/Senior Director-Claims	QUARTERLY	**1st Quarter:**				
			2nd Quarter:				
			3rd Quarter:				
			4th Quarter:				
Activity Name: Claims Processing **Objective:** To improve the quality of claims processing service delivered to providers. **Goals:** ***ninety percent (90%) of all clean claims within twenty (20) calendar days of receipt,** *** ninety-nine percent (99%) of all clean claims within sixty (60) calendar days of receipt and** ***one hundred percent (100%) of all claims within ninety (90) calendar days of receipt.** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Brian Pogue/Senior Director-Claims	QUARTERLY	**1st Quarter:**				
			2nd Quarter:				
			3rd Quarter:				
			4th Quarter:				
Activity Name: Provider Customer Service Call Stats **Objective:** To improve the quality of service delivered to providers calling into the Customer Service department. **Goals: Report the information requested quarterly to the State agency** ***maintain a service level of eighty percent (80%) for incoming calls** **a. Number of provider calls that enter queue (T)** **b. Number of provider calls answered** **c. Number of provider calls answered after 30 seconds (A)** **d. Number of provider calls abandoned after 30 seconds (B)** **e. Number of provider calls received after-hours** **f. Service Level = ((T-(A+B))/T)*100)**	Jason Bollent/Vice President - Member/Provider Communications	QUARTERLY	**1st Quarter:**				
			2nd Quarter:				
			3rd Quarter:				

Monitoring: Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			4th Quarter:	
Activity Name: Member Customer Service **Objective:** To improve the quality of service delivered to members calling into the Customer Service department. **Goals: Report the information requested quarterly to the State agency** ***Service level of eighty percent (80%) for incoming calls** ***calls answered after 30 seconds** ***calls bandoned after 30 seconds** ***Number of member calls that enter queue (T)** *** Number of member calls answered** ***Number of calls received after hours** ***Service level = ((T-(A+B))/T)*100)** Monitoring: Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Rick Morales /Vice President - Member/Provider Communications	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
IX. UTILIZATION OF SERVICE				
Activity Name: Behavioral Health Inpatient Utilization **Objective:** To ensure members receive medically necessary inpatient behavioral health care and services. **Goals:** **• Monitor and reduce behavioral health inpatient admits per 1000 rate.** **• Monitor and reduce behavioral health inpatient average length of stay and admits per 1000 rate.** **• Monitor and reduce behavioral health inpatient utilization by diagnosis.** **• Monitor and reduce inpatient readmissions within 30 days per 1000 members and by diagnosis.** **• Monitor and reduce behavioral health residential treatment average length of stay and admits per 1000 rate.** **• Monitor and reduce behavioral health residential treatment utilization by diagnosis and category of aid.** **• Monitor and reduce residential treatment readmissions within 30 days per 1000 members and by diagnosis.** Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**BH/UM Department**	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Emergency Department Utilization **Objective:** To decrease the number of unnecessary and/or non-emergent visits to the emergency room. **Goals:** **• Implement activities to decrease the number of unnecessary and/or non-emergent visits to the emergency room.** Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE	**CM/UM Department**	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	

METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			4th Quarter:	
Activity Name: Inpatient Utilization **Objective:** To ensure members receive medically necessary inpatient medical care and services. **Goals:** ***Monitor and reduce the medical inpatient admits per 1000 rate.** **• Monitor and reduce medical inpatient average length of stay and admits per 1000 rate.** **• Monitor and reduce medical inpatient utilization by diagnosis.** **• Monitor and reduce readmissions within 30 days per 1000 members and by diagnosis.** Monitoring: Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**CM/UM Department**	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Inpatient Utilization - hospital readmission rates; **Objective:** To ensure members receive medically necessary inpatient medical care and services. **Goals:** **• Monitor and reduce readmissions within 30 days per 1000 members and by diagnosis.** **Monitoring: UMAC and QIC Quarterly** **Monitoring: Quarterly** □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**CM/UM Department**	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Emergency Department Utilization - emergency room diversion **Objective:** To decrease the number of unnecessary and/or non-emergent visits to the emergency room. **Goals:** **• Implement activities to decrease the number of unnecessary and/or non-emergent visits to the emergency room.** **Monitoring: Quarterly** □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**CM/UM Department**	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
X. PHARMACY SERVICES (Insert your market and/or State required pharmacy activities here)				
Activity Name: Drug Exception Review (DER) Processing **Objective:** To maintain compliant will the operational processing of drug exception review cases **Goals:** • **Maintain drug exception review compliance rate of ≥ 98%** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Drug Exception Review (Inter-rater Reliability) **Objective:** To ensure standardization of drug exception review case decisions **Goals:** • **To obtain drug exception review case decision agreement among pharmacists in > 80% of surveyed cases** • **To provide additional training to staff as necessary to maintain acceptable level of case decision agreement** **Monitoring:** Annually □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Medication Recalls Objective: To ensure membership safety by notifying affected members and providers of medication recalls. **Goal:** • **Identify members and prescribing practitioners affected by medication recalls and distribute notification** Monitoring: Quarterly	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	

☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			**4th Quarter:**	
Activity Name: Direct Member Reimbursement **Objective:** To maintain compliant with the operational processing of direct member reimbursement cases **Goals:** • **Maintain direct member reimbursement compliance rate of ≥ 99%** **Monitoring:** PQOC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Pharmacy Appeals Processing **Objective:** To maintain compliance will the operational processing of pharmacy appeals cases **Goals:** • Maintain appeal compliance rate of ≥ 98% **Monitoring:** PQOC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Pharmacy Network Improvement Program (NIP) **Objective:** Improve pharmacy drug list (PDL) compliance to promote cost-effective, quality care for membership **Goals:** • **Identify and educate prescribers considered outliers in medication management** • **Deliver quality messages to improve overall beneficiary outcomes** • **Perform 25 prescriber visits and 50 provider contacts per month** **Monitoring:** PQOC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

Activity Name: Concurrent Drug Utilization Review (cDUR) **Objective:** Utilize messaging provided to pharmacy during the dispensing process to identify need for additional utilization criteria (i.e. POS edits, UM criteria on PDL) to drive appropriate medication management **Goals:** • **Review each cDUR alert type (i.e. drug-drug, drug-age, drug-gender, drug-disease, duplicate therapy, duplicate ingredient, min/max dosage) annually** • **Review cDUR alert type to identify top messaged alerts** • **Review cDUR alert type to identify top POS edits** • **Modify cDUR alert types to address identified concerns in medication management occurring at POS** **Monitoring:** DUR Committee Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Controlled Substance Utilization Management **Objective:** To improve quality and safety of care by limiting over-utilizing members of controlled substance medications to a single pharmacy and prescriber for all prescription needs **Goals:** • **Refer 100% of all lock-in members to case management** • **Perform an annual review of all lock-in members to determine continued inclusion or exclusion in the program** **Monitoring:** PQOC annually □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Retrospective Drug Utilization Review (rDUR) **Objective:** To ensure appropriate medication use through a retrospective review of a specific medications or drug class **Goals:** • **Complete > two (2) rDUR projects annually** • **Provide improvement recommendations to the medication**	**Pharmacy**	Quarterly	**1st Quarter:** **2nd Quarter:**	

use process based off findings of the rDUR **Monitoring:** DUR Committee Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			3rd Quarter: 4th Quarter:	
Activity Name: Antipsychotic Polypharmacy Initiative **Objective:** Reduce the number of members utilizing 2+ antipsychotics continuously **Goals:** • Provide prescriber outreach to notify prescribers of members who are receiving duplication of therapy for antipsychotics • During outreach, provide prescriber with the members' medication history to alert them to other medications being used that may not be prescribed by their practice **Monitoring:** PQOC Annually □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Antipsychotic in the Elderly **Objective:** Reduce the number of members ≥ 65 years old receiving an antipsychotic **Goals:** • Provide prescriber outreach to notify prescribers of members ≥ 65 who are currently prescribed an antipsychotic • During outreach, provide prescriber with the members' medication history to alert them to other medications being used that may not be prescribed by their practice • During outreach, educate prescriber on the risks associated with use of this medication class for member ≥ 65, particularly those with dementia (i.e. black box warning) **Monitoring:** PQOC Annually □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	**Pharmacy**	Quarterly	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XI. PROGRAMS FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS				
Activity Name: EPSDT **Objective:** To improve the health and quality of life of children and adolescents by ensuring they receive timely and appropriate preventive care and treatment. **Goals: To obtain an 80% participation and 80% screening rate** **Monitoring:** Semi-Annually □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement Staff	Semi- Annual	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: High Risk Pregnancy Program **Objective:** To improve the health and birth outcomes of pregnant women and infants. **Goals:** **• Implement a high risk pregnancy program.** **• Implement activities to increase the frequency and number of prenatal care visits pregnant women receive. Baseline rate HEDIS 2016.** **• Implement activities to decrease the percentage of low birth weight babies. Baseline rate in 2016.** **• Implement activities to increase gestational age at birth. Baseline rate in 2016.** **• Monitor the number of members enrolled in the high risk pregnancy program.** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality Improvement Staff	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

Activity Name: Long Term Care Services and Supports **Objective:** To ensure members with complex managed long term care needs receive appropriate care and coordination of needed services. **Goals:** • Implement a managed long term care services program targeted to members with long term care needs • Implement activities to improve the health and quality of life of members enrolled in managed long term care management. • Monitor the number of members enrolled in managed long terrm care management. **Monitoring:** UMAC and QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	**Long Term Services and Supports**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Behavioral Health Service and Supports **Objective:** To ensure members with complex behavioral health needs receive appropriate care and coordination of needed services. **Goals:** **• Implement behavioral health services program targeted to members with behavioral health needs.** **• Implement activities to improve the health and quality of life of members with behavioral health needs.** **• Monitor the number of members with behavioral health needs.** **Monitoring:** UMAC and QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	**Long Term Services and Supports**	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XII. CASE MANAGEMENT (INSERT YOUR MARKET/ STATE SPECIFIC REQUIREMENTS HERE)				
Activity Name: Behavioral Health Case Management **Objective: To ensure members with complex behavioral health care needs receive appropriate care and coordination of needed services.** **Goals:** **• Implement a behavioral health case management program targeted to members with complex behavioral health needs and children who have been reviewed for behavioral health drug exception.** **• Improve health as evidence by HEDIS scores and improve quality of life of members based on SF-8 scores.** **• Monitor the number of members enrolled in behavioral health case management.** **Monitoring: Quarterly** **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	BH/CM Departments	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Case Management **Objective:** To ensure members with complex medical needs receive appropriate care and coordination of needed services. **Goals:** *** Maintain a case management program targeted to members with complex medical needs.** **• Implement activities to improve the health and quality of life of members enrolled in case management.** **• Monitor the number of members enrolled in case management.** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM Department	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

Activity Name: Case Management for Special Health Care Needs **Objective:** To ensure members with complex medical needs receive appropriate care and coordination of needed services. **Goals:** *** Maintain a case management program targeted to members with special health care medical needs.** **• Implement activities to improve the health and quality of life of members enrolled in case management.** **• Monitor the number of members enrolled in case management.** **Monitoring:** Quarterly **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	CM Department	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
XIII. DISEASE MANAGEMENT (INSERT YOUR MARKET/ STATE SPECIFIC REQUIREMENTS HERE)				
Activity Name: Disease Management **Objective:** To ensure members with chronic medical conditions receive education regarding their chronic condition, and interventions to ensure improved health and quality of life. **Goals:** **• Maintain Disease management programs targeted to members with asthma and diabetes chronic conditions.** **• Implement activities to improve the health and quality of life of members enrolled in disease management.** **• Monitor the number of members enrolled in disease management.** **Monitoring: Quarterly** **□ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	DM Department	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XIV PERFORMANCE IMPROVEMENT PROJECTS (PIP) (INSERT YOUR MARKET/ STATE SPECIFIC REQUIREMENTS HERE)				
Activity Name: State Specific Performance Improvement Projects **Objective: Performance Improvement of state specific required projects** **Goals: To align with State agency requirements for performance improvement projects** **Monitoring:** Annually □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Topic to be defined by the state agency	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XV. CULTURAL COMPETENCY				
Activity Name: Cultural Needs and Preferences **Objective:** To ensure members have access to a provider network that meets their cultural, linguistic, ethnic, and racial needs. **Goal:** • **Monitor and respond to member grievances quarterly regarding cultural, linguistic, ethnic, and racial needs.** • **Annually assess the cultural, linguistic, ethnic, and racial needs of the membership and adjust the availability of practitioners within the network as necessary.** **Monitoring:** Annually □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Felicia Thomas/Senior Director -Product | Pamme Taylor/Vice President - Advocacy and Community Based Programs	Annually	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XVI. DELEGATION OVERSIGHT (INSERT YOUR MARKET/ STATE SPECIFIC REQUIREMENTS HERE)				
Activity Name: Review and assess delegation oversight processes **Objective:** To confirm delegation oversight and issues identified are closed in a timely manner. **Goal:** • Number delegation reviewed by due date 90%. • Percentage CAPS closed by initial due date 90%. **Monitoring:** QIC Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Chris Price/Senior Director-Corporate Audit and Oversight	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

Each delegated entity will be tracked separately.

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XVII. HEDIS OUTCOMES AND PREVENTIVE HEALTH MEASURES				
A. EFFECTIVENESS OF CARE				
Preventive and Screening				
Activity Name: Adult BMI Assessment (ABA) **Objective:** To improve the percentage of members 18-74 years of age who had an outpatient visit and whose BMI was documented. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Breast Cancer Screening (BCS) **Objective:** To improve the percentage of women 40 -69 years of age who had a mammogram to screen for breast cancer. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring: Quarterly** □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Cervical Cancer Screening (CCS) **Objective:** To improve the percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring: Quarterly** □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	

METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			4th Quarter:	
Activity Name: Childhood Immunization Status (Combo 2) (CIS) **Objective:** To improve the percentage of children 2 years of age who have combo 2 vaccinations by their second birthday. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Chlamydia Screening in Women (CHL) **Objective:** To improve the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Lead Screening in Children (LSC) **Objective:** To improve the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) **Objective:** To improve the percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had BMI percentile documented, nutritional counseling, and physical activity counseling. **Goals: NCQA 75th percentile HEDIS based on current rates**	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter:	

Monitoring: Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			3rd Quarter:	
			4th Quarter:	
Respiratory Conditions				
Activity Name: Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis **Objective:** To decrease the percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who are not dispensed an antibiotic prescription. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Pharmacotherapy Management of COPD Exacerbation **Objective:** To improve the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter and who were dispensed appropriate medications. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter: 4th Quarter:	
Activity Name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD **Objective:** To improve the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly	QM Coordinator/QI Director	QUARTERLY	1st Quarter: 2nd Quarter: 3rd Quarter:	

□ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR			**4th Quarter:**	
Activity Name: Appropriate Testing for Children With Pharyngitis **Objective:** To improve the percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Appropriate Treatment for Children With Upper Respiratory Infection **Objective:** To decrease the percentage of children 3 months - 18 years of age who are given a diagnosis of upper respiratory infection and were not dispensed an antibiotic. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Use of Appropriate Medications for People With Asthma **Objective:** To improve the percentage of members with asthma 5-64 years of age who were prescribed appropriate asthma medication. **Goals: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Cardiovascular Conditions				

Activity Name: Cholesterol Management for Patients With Cardiovascular Conditions **Objective:** To improve the percentage of members 18-75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) or who had a diagnosis of ischemic vascular disease (IVD) and had both an LDL-C screening and LDL-C control. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Controlling High Blood Pressure (CBP) **Objective:** To improve the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140-90). **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Diabetes				
Activity Name: Comprehensive Diabetes Care Testing (HA1C) **Objective:** To improve the percentage of members 18-75 years of age who had an eye exam, HgbA1c, LDL-C screening & nephropathy screening test. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	Quarterly	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Behavioral Health				
Activity Name: Antidepressant Medication Management (AMM) **Objective:** To improve the percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication.	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:**	

Goal: NCQA 75th percentile HEDIS based on current rates **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**3rd Quarter:**	
			4th Quarter:	
Activity Name: Follow-Up Care for Children Prescribed ADHD Medication **Objective:** To improve the percentage of children 6-12 years of age with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Follow-Up After Hospitalization for Mental Illness (FUH) **Objective:** To improve the percentage of members 6 years of age and older discharged for treatment of a selected mental health disorder who have a follow-up outpatient visit. **Goals: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
II. Access/ Availability of Care				
Activity Name: Adults' Access to Preventive/Ambulatory Health Services **Objective:** To improve the percentage of members 20-64 years of age who had an ambulatory or preventive care visit. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

Activity Name: Children's and Adolescents Access to PCP (CAP) **Objective:** To improve the percentage of members 25 months - 19 years of age who had at least one visit with a PCP. **Goals: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Timeliness of Prenatal Care Rate (PPC) **Objective:** To improve the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the Plan. **Goals: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Timeliness of Postpartum Care Rate (PPC) **Objective:** To improve the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. **Goals: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
C. Utilization and Relative Resource Use				
Utilization				
Activity Name: Adolescent Well-Care Visits (AWC) **Objective:** To improve the percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:**	

Monitoring: Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**			**4th Quarter:**	
Activity Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **Objective:** To improve the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who receive Initiation of AOD Treatment and Engagement of AOD Treatment. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring:** Quarterly □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Well Child Visits in the First 15 Months of Life (W15) **Objective:** To improve the percentage of members who turned 15 months old and who had six or more well-child visits with a PCP during their first 15 months of life. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring** Quarterly □ ***PREVIOUSLY IDENTIFIED ISSUES*** **CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	
Activity Name: Well Child Visits 3-6 Years of Life (W34) **Objective:** To improve the percentage of members 3-6 years of age who had at least one well-child visit with a PCP. **Goal: NCQA 75th percentile HEDIS based on current rates** **Monitoring: Quarterly** □ **PREVIOUSLY IDENTIFIED ISSUES CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR**	QM Coordinator/QI Director	QUARTERLY	**1st Quarter:** **2nd Quarter:** **3rd Quarter:** **4th Quarter:**	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe		Quarterly Activity Summary
XVIII. COMMUNITY ENGAGEMENT				
Activity Name: Member Advisory Committee **Objective:** To form a collaborative partnership with members and ensure that members voices/perspectives are heard and have a meaning role in shaping and tailoring the WellCare of Nebraska delivery model. **Monitoring:** Committee Meetings to QIC Quarterly ☐ **PREVIOUSLY IDENTIFIED ISSUES** CHECK THIS BOX IF THE METRIC WAS NOT MET ANY TIME IN THE PREVIOUS YEAR	Quality/Community Advocacy	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XXIII. EVALUATION OF QI PROGRAM				
Activity Name: QI Program Description **Objective:** To enhance members' health and quality of life by improving the quality of services the Plan provides. **Goal:** • Develop and implement the 2016 QI Program Description. **Monitoring:** UMAC and QIC Annually	QM Director	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: QI Program Evaluation **Objective:** To enhance members' health and quality of life by improving the quality of services the Plan provides. **Goal:** • Evaluate the effectiveness of the QI Program and include necessary program enhancements in the 2016 QI Program Description. **Monitoring:** UMAC and QIC Annually	QM Director	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: QI Polices and Procedures **Objective:** To enhance members' health and quality of life by improving the quality of services the Plan provides. **Goal:** • Evaluate the effectiveness of the QI Policies and Procedures and include necessary program enhancements in revised versions **Monitoring: C360 Annually and Ad Hoc**	QM Director Michaela Flanagan	Annually and Ad Hoc	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	

			4th Quarter:	
Activity Name: QI Work Plan **Objective:** To enhance members' health and quality of life by monitoring the quality of services the Plan provides. **Goal:** • Monitor quality management and quality improvement activities **Monitoring: State and Committees Annually for Approval**	QM Director	Annually and Ad Hoc	1st Quarter:	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: QI Committee Minutes **Objective:** To enhance members' health and quality of life by monitoring the quality of services the Plan provides. Goal: Monitor QM committee activities Report: a. Date of QM committee meeting b. Date subcontractor QM committee minutes submitted to DHS c. Issues with compliance: "Yes" or "No **Monitoring: State and Committees Annually for Approval**	QM Director	Quarterly and Ad Hoc	1st Quarter:	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff Person/People	Completion Timeframe	Quarterly Activity Summary	
XIX. QUALITY INITIATIVES				
EQRO AUDITS				
Activity Name: Annual EQRO Audits Objective: To successfully complete the annual EQRO audit. **Goals:** • Successfully complete the annual EQRO audit that results in minimal findings. • Implement corrective actions as identified. **Monitoring:** Executive Leadership Team Annually - QIC Annually	Quality Improvement Staff	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
XX. NCQA ACCREDITATION				
Activity Name: NCQA Accreditation **Objective:** To obtain new health plan accreditation through NCQA. **Goal:** • Obtain NCQA health plan accreditation in accordance with contract go-live date. **Monitoring:** UMAC and QIC Semi-Annually	Quality Improvement Staff	TBD	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

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Quality Improvement Activity	MCO Responsible Staff	Completion Timeframe	Quarterly Activity Summary	
XXIII. QAPI PROGRAM REPORTING REQUIREMENTS				
Activity Name: Quality Oversight Committee **Objective:** To provide Committee activity summary as described in Section IV. M - Quality Management **Goal:** • 45 calendar days following the most recent quarter **Monitoring:** UMAC and QIC Annually Reporting: State Requirement	Quality Improvement	Quarterly	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Quality Performance **Objective:** To provide summary data and metric results as determined by MLTC. **Goal:** • 45 calendar days following the most recent quarter **Monitoring:** UMAC and QIC Annually	Quality Improvement	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	
Activity Name: Member Advisory Committee Report Summary **Objective:** To provide summary narrative on the activities of the MCO's Member Advisory Committee as described in Section IV. M. - Quality Management **Goal:** • 45 calendar days following the most recent quarter **Monitoring:** UMAC and QIC Annually	Quality Improvement	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	

			4th Quarter:	
Activity Name: Critical Incident Report Summary **Objective:** To provide summary data on the number of critical incident reports by behavioral health facility and location. **Goal:** • 45 calendar days following the most recent quarter **Monitoring:** UMAC and QIC Annually	Quality Improvement	Annually	**1st Quarter:**	
			2nd Quarter:	
			3rd Quarter:	
			4th Quarter:	

SECTION IV.M QUALITY MANAGEMENT

69. Describe how the MCO will measure and track the outcome of individual quality improvement interventions over time. (*Page limit 3 pages)*

MEASURING QUALITY IMPROVEMENT INTERVENTIONS

In 2014, WellCare began piloting a new methodology to measure and track the outcome of individual quality improvement interventions over time. The methodology is based on the ***Model for Improvement*** developed by the Associates in Process Improvement. It uses rapid-cycle improvement which requires a collaborative approach with cross-functional interdepartmental teams that also include network providers and external community experts. This change in approach has been well received and effective. As a result, we have begun adopting the ***Model for Improvement*** as our change process throughout the organization, both for formal performance improvement projects (PIPs) as well as other quality improvement interventions.

Quality Improvement Intervention Process

WellCare's rapid cycle quality improvement process is broken into four phases: **identify**, **design**, **implement/test** and **evaluate**. Each of the four phases is briefly described below:

- **Identify:** During the *Identify* phase, we pinpoint the health outcome or area we are trying to improve and the barriers to improvement. We study current data trends and relevant research to support the quality improvement topic selection utilizing national, state, local, and historical WellCare data and industry knowledge.
- **Design:** During the *Design* phase, we select interventions that will directly affect our ability to achieve the quality improvement goals. The team, which includes one or more quality improvement data analysts, chooses a data collection methodology that will enable us to test interventions and evaluate outcomes. We establish baseline data and determine a benchmark.
- **Implement/Test:** We first implement the interventions on a small scale using pilot sites. As part of the *Implement* phase process, we develop a measurement plan and use a rapid cycle Plan-Do-Study-Act (PDSA) process, collecting data on a biweekly, semi-monthly, or monthly basis, as appropriate. Using a run chart, we plot and monitor progress on outcomes, process and balance measures (which help determine if there are unintended consequences) over a designated period of time compared to our baseline.
- **Evaluate:** At the conclusion of the quality improvement interventions, the team identifies and summarizes key findings, determines if there was meaningful improvement, identifies and compares successful and unsuccessful interventions, lessons learned and outcomes. The team determines whether further testing is needed or if the pilot should be scaled up.

Quality Measurement Infrastructure

Measurement of WellCare's quality improvement interventions is backed by a robust data collection and analytic infrastructure comprised of data managers and quality improvement analysts who collect and analyze the impact of quality improvement interventions over time using a variety of cost, utilization, and quality measurement databases. These personnel are described below.

Corporate Quality Measurement Staff

WellCare has established a corporate team structure to support data collection, data analysis, and reporting functions for all of its subsidiary plans. The multidisciplinary team, led by WellCare's Vice President for Population Outcomes, is composed of analysts, developers, data administrators, and informatics experts who know our systems, understand the data within the systems, and have the

experience to report the data in a manner that supports the analytics required to effectively manage care for our Nebraska members. The various roles of the WellCare quality corporate support team include:

- The **Quality Analytics** department is responsible for analysis related to all aspects of quality, predictive modeling, retrospective analysis and trend analysis from a QI perspective. This skilled group of individuals has decades of health care analytics reporting experience providing data retrieval, management, and mining, report writing and graphics, and statistical analysis.
- The **Medical Economics** department is responsible for analysis related to all aspects of quality, predictive modeling, retrospective analysis, and trend analysis from a cost and utilization perspective. This team is able to pull data to develop reports, studies, analyses and ad hoc requests using tools such as SAS® and Cognos. The team uses information available in standard claims fields including but not limited to CPT, diagnosis (primary, secondary, etc.), DRG, specialty type, provider type, provider, facility, member, member type, bill type, denials, appeals, and authorizations.
- The **Operational Reporting** team, which includes experienced developers who are adept at operationalizing key regulatory, quality, and performance reporting. The primary focus of this group is to develop reports that are run automatically on a periodic (weekly, monthly, quarterly, annually, or other) basis and are used either for regulatory purposes or for real-time monitoring.
- The **Advocacy and CommUnity-Based Programs** department maintains the technical systems to capture access and use of social services by members and their families at the transactional level. In addition, the team assembles community-based, public health data on which to identify health trends that could impact our membership. And, using the social service referral data, identifies potential gaps in social service availability to pilot community-based solutions for filling those gaps.

WellCare of Nebraska Quality Measurement Staff

In addition to the corporate resources we use to measure and evaluate quality improvement interventions, WellCare of Nebraska's Quality department will include a quality management/ performance and quality improvement coordinator who will develop, coordinate, and implement WellCare quality strategies and interventions, including the collection of relevant and meaningful indicators for monitoring and evaluating the quality and appropriateness of care/ service across the continuum. Additional staff will include quality improvement analysts, project managers, and nurse specialists.

Measuring Quality Improvement: Data Sources

WellCare's quality measurement staff has access to a number of data sources that allow us to effectively track and monitor progress in meeting our quality improvement goals. Quality improvement teams use reports from these data sources to monitor quality improvement interventions. These data sets include:

- **HEDIS Data:** WellCare uses a NCQA HEDIS®-certified vendor to calculate HEDIS® and HEDIS®-like measures on a monthly and annual basis. WellCare's **Quality Analytics** team creates excel based reports that show the current performance rates in comparison to benchmarks.
- **CAHPS Data:** WellCare uses a NCQA-certified CAHPS vendor that identifies a random sample of our membership and conducts both the CAHPS Medicaid Adult Survey and the Medicaid Child Surveys on an annual basis. The QI Department assesses the data, compares it to prior year performance, evaluates how it is performing against peers, identifies key drivers and barriers to improvement and develops interventions to improve the members' experience of care.
- **Claims and Encounter Data:** Claims and encounter data are analyzed regularly to identify the health care needs of the population by identifying the diagnostic categories that are the most prevalent, broken down by demographic data, including race and ethnicity. This data is used to identify gaps in care, as well as over and under-utilization.
- **Authorization Data**: A monthly report summarizing authorization data is used to monitor utilization trends for inpatient services including birth/NICU, behavioral health, medical, surgical, and

observation. We utilize this to identify trends across individual and groups of providers. This helps us monitor adherence to clinical practice guidelines and identify emerging patterns of care.

- **Call Center and Appeal and Grievance Data:** One of the most important ways that we are able to identify areas for quality is through our call center, complaint reporting and appeal and grievance procedures. Complaint and appeal information for both members and providers is used to produce quarterly and ad hoc reports which include aggregate totals and trend analyses.
- **Medical Record Review Data:** Annual medical and behavioral health record reviews are conducted to measure compliance with general medical record keeping practices, confidentiality of member data, adherence to certain preventive care guidelines and coordination and continuity of care.
- **Care Plan Data:** WellCare is in the process of building a customized enhanced platform which will include a comprehensive 360-degree view incorporating key clinical, financial, legal, and lifestyle data that are unique to the individual member. These data will be aggregated in order to assist in real-time quality improvement and enhanced provider engagement.
- **Community Assessment and Feedback:** WellCare utilizes census, environmental, economic, social and clinical/health care data for the community and combines it with data regarding our membership.
- **Case Management and Disease Management Audits:** Compliance reviewers conduct monthly case audits for each case manager and communicates the findings and trends to case management leadership. Audit findings support analysis of quality improvement interventions
- **Provider Satisfaction Surveys:** We collect provider feedback through annual provider satisfaction surveys. We analyze the survey results to identify, monitor, and track quality improvement opportunities and interventions.
- **Pharmacy Data:** Pharmacy data is analyzed to identify trends that assess the current state of our pharmacy program. The data analysis is used to identify prescriber outliers, evaluate Member outcomes, determine areas requiring prescriber outreach or education, and identifying classes where generic usage can be increased.

Monitoring Outcomes: Clinical and Executive Review of Quality Improvement Interventions

Findings from our Quality Assessment and Performance Improvement (QAPI) interventions for Heritage Health members will be reported to clinical and executive leadership including WellCare of Nebraska's medical director, Quality Assessment and Performance Improvement Committee (QAPIC) and other (QAPI)-related committees. The QAPIC directs and reviews WellCare's quality improvement and utilization management activities, and has the authority to create and provide direction to work groups, committees, and departments within the health plan to assess, investigate, and take action related to the health care services received by members.

SECTION IV.M QUALITY MANAGEMENT

70. Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes. *(Page limit 5 pages)*

IMPROVING THE HEALTH CARE STATUS OF MEMBERS BY USING DATA TO DRIVE IMPROVEMENTS

WellCare provides a broad range of well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and program performance by partnering with members, providers, community-based organizations, and state and local agencies to provide for integrated, person-centered, evidence-informed and high-quality health care. These efforts are supported by our comprehensive quality assurance and performance improvement (QAPI) Program. As part of our continuous quality improvement strategy, WellCare uses the results of HEDIS®, HEDIS®-like and state performance measures, member satisfaction surveys, and data from operational and clinical areas to drive improvements and positively affect the health care status of members. Quality improvement teams use reports from a variety of data sources to monitor and measure quality improvement interventions. Below, we highlight examples of WellCare's experience implementing changes to improve programmatic and member health outcomes.

Healthcare Effectiveness Data and Information Set

WellCare has more than 15 years of experience using an NCQA HEDIS®-certified vendor to calculate HEDIS® and HEDIS®-like performance measures on a monthly and annual basis. Our Quality Analytics department, a corporate unit that supports all of our state health plan affiliates, uses NCQA certified quality-measure reporting software that calculates measures using administrative data sources. The Quality Analytics department creates excel based reports that show the current performance rates in comparison to benchmarks. For state specific measures, the department populates state-required reporting templates to assist in quality improvement efforts.

In order to drive improvements on the frontline of where care is delivered, WellCare creates Provider Care Gap reports that address HEDIS® care gaps for each of our high volume primary care providers (PCP). The report includes the PCP's compliance rate for HEDIS® measures that can be impacted by a PCP at the provider level. The report identifies members with a gap in care, such as a missed immunizations, lead screenings or well-child visits. Our local Provider Relations (PR) representatives and Clinical HEDIS® Practice Advisors (CHPAs) meet onsite with these high-volume network providers that care for 80 percent of the membership in a given market and their office teams to deliver and review the Provider Care Gap reports. CHPA's and PR representatives provide education on HEDIS® measures and closing member care gaps and identify opportunities and strategies for improving the quality of member care and reducing costs. They review the Provider Care Gap reports with the PCP to identify areas of excellence and opportunities for improvement, as measured by HEDIS®, as compared to their peers as well as state and national benchmarks if available. In addition to regular on-site assistance for these providers, we offer ad hoc assistance via email or conference calls to strategize solutions to complex clinical issues and work towards resolution of deficiencies. We track the success of our interactions with the providers in closing gaps in member care by reviewing the data every month to determine compliant HEDIS® measures.

Example 1: Antidepressant Medication Management

As part of WellCare's ongoing HEDIS® monitoring efforts, our Quality Analytics department reported that the results for two adult antidepressant medication management measures among our affiliate state health plans in Georgia and Kentucky were underperforming. The HEDIS® measure is defined as the 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:** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective Continuation Phase Treatment:** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

In order to drive improvements and positively affect the health care status of our Medicaid members in Georgia and Kentucky, WellCare implemented a letter campaign to members and providers to serve as reminders. Letters were mailed to our members who had been prescribed a new antidepressant medication that advised them to follow up with their physician. At the same time, we mailed letters to the physician of record advising that their members have recently begun a new medication and has not yet had the follow up required. A list of members assigned to the provider was attached for follow up. In 2014, we mailed nearly 6,000 letters to members and providers in Georgia and over 17,000 letters in Kentucky.

Once the intervention was in place, we continued to monitor performance on the two antidepressant medication treatment measures. Across both measures in Georgia and Kentucky, we found results as shown in **Figure 3**.

Figure 3

Results of Member and Provider Letter Campaign for Antidepressant Medicaid Management			
Measure	**Baseline Performance (CY2013)**	**Performance (CY2014)**	**%-Point Improvement Over Baseline**
Georgia			
Effective Acute Phase Treatment	44.15%	46.92%	2.77
Effective Continuation Phase Treatment	29.43%	30.37%	0.94
Kentucky			
Effective Acute Phase Treatment	49.86%	52.29%	2.43
Effective Continuation Phase Treatment	33.53%	37.61%	4.08

Example 2: Patient Care Advocate Program

WellCare of Florida (Staywell), piloted a Patient Care Advocate (PCA) Program in 2013. The program is designed to improve the health and well-being of members and close care gaps. The PCA, a WellCare employee, is embedded in a large pediatric practice that cares for approximately 20,000 children and adolescents who are WellCare members. The PCA meets with members prior to and after appointments for discussion of any gaps in care. The PCA schedules follow up appointments and assists with any barriers identified (e.g., transportation). Prior to the follow up appointment, the PCA calls members to remind them of the follow up and determine if any barriers exist in making it to the appointment. On an ongoing basis, the PCA monitors whether any identified care gaps are closed and works with members to determine the case and address any scheduling or transportation barriers. The PCA meets weekly with the PCPs and the administrator of the practice to discuss relationship and advocacy objectives. To assess the efficacy of the program, WellCare tracks the practice's monthly HEDIS® rates, monthly care gaps closed, and annual final HEDIS® rates.

Figure 4 summarizes HEDIS® rates for Pediatric Associates, Inc. in Miami, an Independent Practice Association (IPA) that implemented the PCA Program in 2014. Baseline data for 2013 is provided for comparison purposes.

Figure 4

Results of Member and Provider Letter Campaign for ADHD Follow Up Care			
Measure	Baseline Performance (CY2013)	Performance (CY2014)	%-Point Improvement Over Baseline
ADHD Initiation Phase - Visit	37.80%	54.08%	16.28
Adolescent Immunizations	85.59%	85.82%	0.23
Asthma Controller Medication	91.53%	98.51%	6.98
Chlamydia Testing	33.70%	46.98%	13.28
Child/Adolescent Access 25 months – 6 years	78.10%	79.30%	1.20
Well Child Visit 3 – 6 years	39.88%	43.15%	3.27

Example 3: ADHD Medication Follow Up for Children

In the course of the annual quality improvement evaluation process where quality improvement activities, interventions and HEDIS® measure data and metrics are analyzed, WellCare's quality improvement departments or staff identified the need for a clinical practice guideline for the treatment of Children and Adolescents' ages 4-18 with ADHD. There were no standard guidelines posted for WellCare affiliate state health plans to reference for determining appropriate treatment. In response, WellCare drafted guidelines for ADHD treatment based on available evidence based literature and input from clinical experts. In 2011, the guidelines were approved by WellCare's Medical Policy Committee, a corporate review body, and were approved by the respective Medicaid state-based utilization management committees. The policy is reviewed annually and modified based on further evidence-based practices and clinical opinion, including guidance from the American Pediatric Association.

In order to monitor changes in members' health outcomes, HEDIS® measures are monitored monthly and reported quarterly to committees and annually to NCQA. The follow up care for children prescribed ADHD medication measure, which calculates the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who 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 was monitored. Two rates are reported:

- **Initiation Phase:** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- **Continuation and Maintenance (C&M) Phase:** The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended

In order to drive improvements in these performance measures, WellCare implemented a letter campaign to members and providers to serve as reminders of follow up. An ADHD member letter was mailed to the parent or caregiver of identified members' ages 6-12 that has been prescribed a new medication (Initiation Phase) and advised them to follow up with their physician within 30 days. The letter also included important information on behavioral health and support services. At the same time, letters were mailed to the physician of record advising that their members had recently begun a new medication and had not yet had the 30 day follow up required. A list of members assigned to the provider was attached to the letter for follow up.

Once the intervention was in place, we continued to monitor performance on the two ADHD medication follow up measures. Across both measures in Kentucky, where nearly 4,500 letters were mailed, we

found strong results as shown in **Figure 5**.

Figure 5

Results of Member and Provider Letter Campaign for ADHD Follow Up Care			
Measure	Baseline Performance (CY2012)	Performance (CY2014)	%-Point Improvement Over Baseline
Kentucky			
Initiation Phase Treatment	50.0%	61.5%	11.5%
Continuation Phase Treatment	20.0%	69.6%	49.6%

Member Satisfaction Surveys: Consumer Assessment of Healthcare Providers and Systems

The results of member satisfaction surveys have proved to be an invaluable tool for WellCare to evaluate the access and quality of care and services provided to our members and identify opportunities for improvement. WellCare uses an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) vendor that identifies a statistically valid random sample of our Medicaid and CHIP membership and annually conducts Adult and Child CAHPS® surveys. Our vendor compiles the results, analyzes the data and provides WellCare and its affiliate health plans with a comparison of our performance against national and state benchmark standards. WellCare uses the data to evaluate how the plan is performing, identify key drivers and barriers to improvement, and develop interventions to improve the members' experience of care with their providers and WellCare.

Example 4: Improving WellCare of Illinois Member Satisfaction

Below are example initiatives from WellCare's Illinois affiliate health plan. **Figure 6** shows several CAHPS® Adult and Child measures which did not meet WellCare's goals for member satisfaction. As a result, WellCare conducted a barrier analysis and implemented a variety of initiatives:

- Called new members at 30 and 60 days post-enrollment to ensure they are happy with WellCare
- Improved processes that allow members to change their PCP
- Developed and distributed a CAHPS® quick reference guide to providers
- Sent post card mailings to members that addressed access and availability concerns
- Distributed CAHPS®-like surveys at health fairs to help members understand the purpose
- Changed customer service team processes to ensure members were happy with their experience
- Published articles in the provider newsletter addressing ways to improve member satisfaction scores

Figure 6

WellCare of Illinois Medicaid Member Satisfaction Improvements				
Measure	Survey	Baseline Performance 02/14-05/14	Performance 02/15-05/15	%-Point Improvement Over Baseline
Getting Needed Care composite	Adult	69.8%	73.5%	3.7
Health Plan Rating	Adult	38.8%	58.1%	19.3
Getting Care Quickly	Child	74.8%	78.3%	3.5
How Well Doctors Communicate	Child	89.3%	93.8%	4.5

Cost and Utilization Data

WellCare also analyzes measures of inpatient, outpatient, emergency department utilization and costs, which can be rolled up and compared across physicians or at the physician group level. Our Medical Economics department supports analysis and monitoring for all of our affiliate state health plans.

Example 5: Integrated Care Management for Members with Severe Mental Illness (SMI) and Chronic Medical Conditions

In 2013, WellCare of Kentucky piloted an initiative to improve health outcomes and quality of care for adult members with a Severe Mental Illness (SMI) and five additional chronic medical conditions, including asthma, COPD, diabetes, hypertension/heart disease and AIDS. The goal of the program was to make a positive impact on members' utilization of the emergency department, hospital admissions and readmissions, frequency of PCP/psychiatrist visits and medication adherence by implementing face-to-face integrated case management using a clinical dyad consisting of a nurse case manager and a social worker case manager. The clinical dyads participating in the pilot received core case management training (motivational interviewing, case management safety and documentation) as well as condition specific training (schizophrenia, bipolar disorder, anxiety, depression, suicide assessment/prevention, substance use disorder, asthma, COPD, diabetes, hypertension/heart disease and obesity). The clinical dyad continued to work with members and their families, treating providers and identified social support systems via face to face visits to coordinate needed care and assist the member to remain stable in the community. The pilot consisted of 43 members who actively participated. Interventions occurred between May and October 2013. The results of the pilot are listed in **Figure 7**.

Figure 7

Results of Member and Provider Letter Campaign for ADHD Follow Up Care	
Measure	**% Change From Baseline**
Total Medical Expenses	31%
Emergency Department Visits	10%
Inpatient Expenses	66%
Outpatient Expenses	24%
Professional Expenses	11%
Baseline Member claims data measured: 2/1/2012 – 4/30/2013 *Pilot program results data measured: 5/1/2013 – 10/31/2013*	

SECTION IV.M QUALITY MANAGEMENT

71. Describe how the MCO will assess the quality and appropriateness of care furnished to members with special health care needs, members with co-occurring physical and behavioral health concerns, and dual-eligible members. *(Page limit 3 pages)*

ASSESSING QUALITY AND APPROPRIATENESS OF CARE FURNISHED TO VULNERABLE POPULATIONS

WellCare assesses the quality and appropriateness of care furnished to all members through our comprehensive, systematic, and data-driven quality assurance and performance improvement (QAPI) Program. Our QAPI Program reviews the entire range of services including those provided to members with special health care needs, members with co-occurring physical and behavioral health concerns and dual-eligible members. Evaluation and monitoring activities cover the quality and appropriateness of the physical, behavioral, pharmacy and social services that our members need. Our QAPI Program builds upon WellCare's holistic and member-centric model of care which coordinates and integrates prevention-focused physical, behavioral, pharmacy, and social support services.

METHODS FOR ASSESSING QUALITY OF CARE

Health Care Effectiveness Data and Information Set (HEDIS®) Measurement

WellCare uses a National Committee for Quality Assurance (NCQA) certified vendor to calculate Healthcare Effectiveness Data and Information Set (HEDIS®) data and HEDIS®-like measures on a monthly and annual basis using a combination of administrative and clinical (chart review) data sources. Using eligibility file, encounter data and utilization data, our Quality Analytics department is able to stratify the data by population cohorts, including members with special health care needs, members with co-occurring physical and behavioral health concerns, and dual-eligible members. This will provide us the ability to monitor HEDIS performance for these populations and design, develop, and implement quality improvement interventions tailored to their needs.

Record Review

Annual medical and behavioral health record reviews are conducted to measure compliance with general medical record keeping practices, confidentiality of member data, adherence to certain preventive care guidelines and coordination and continuity of care. The review process identifies areas of record documentation and management that may be improved and provides feedback to the provider. Those who do not achieve a passing score are required to create and implement a corrective action plan. WellCare monitors completion of the corrective action plan and re-audits the provider to ensure deficiencies have been successfully remediated. Providers who are non-cooperative with auditing, have serious identified issues with delivery or documentation of care, or fail to make improvement following interventions or corrective action plans will be referred to the WellCare of Nebraska medical director, Network Management and/or UM leadership for appropriate intervention and resolution.

Case Management and Disease Management Audits

WellCare's Health Services Compliance team conducts monthly case audits for each WellCare case manager and disease management nurse. Findings and trends are communicated to Case Management (CM) and Disease Management (DM) leadership. Management analyzes the audit findings to provide coaching opportunities for the department and the individual case managers and disease management nurses. Health Services will collaborate with our Nebraska Quality department to address any quality of care issues and improve CM and DM for our members. In addition, our internal training/auditing staff supplements these audits using an extensive process which ensures that CM/DM timeliness, documentation, and activities are in compliance with our internal policies and procedures, our accrediting bodies and our contracts. These audits are used to educate audited case managers and CM/DM teams,

including when find cases that were managed well and had optimal outcomes.

Provider Credentialing

WellCare sets credentialing and re-credentialing criteria for provider network participation in compliance with applicable local, state, and federal requirements. WellCare follows NCQA guidelines for recredentialing as well respective state and federal contract requirements for credentialing. Performance information is a key component of the provider re-credentialing process, which evaluates, among other elements, the provider's quality of patient care, clinical performance, and utilization of resources. We use information from a variety of sources, including the provider application, primary source verification, medical record review audits, and relevant findings from provider profiling. Providers that fail to meet established standards, have instances of poor quality, or are non-compliant with contractual, state, or federal regulations will be reviewed by the WellCare of Nebraska Credentialing and Peer Review Committee, with avenues of recourse including corrective actions, sanctions or provider termination.

Community Assessment and Feedback

WellCare uses a system of care approach to quality measurement focusing on the health of the population to improve quality outcomes for our individual members. In doing so, WellCare utilizes census, environmental, economic, social and clinical/health care data for the community and combines it with data regarding our membership. Using a five-step process, WellCare reviews the analysis with a cross-functional team to collaboratively design outreach efforts in critical areas that will improve the quality of care and the quality of life of our members, their families and the community-at-large.

Unique Quality of Care Considerations for Vulnerable Populations

Members with Special Health Care Needs

Individuals with special health care needs (SHCNs) are defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. WellCare will utilize Medicaid historical claims data (if available) to identify members who meet our guidelines for SHCN determination. These guidelines will be submitted in writing to MLTC for approval prior to their proposed implementation. These groups may include, but are not limited to: adults with high risk pregnancies; chronic conditions; cancer; multiple morbidities; behavioral health conditions; substance abuse; social conditions such as homelessness and limited language capabilities; adults with polypharmacy; emergency department overutilization; hospital readmissions within 30 days; children with chronic conditions; children who take medication for any behavioral/medical condition that has lasted, or is expected to last, at least twelve months; children who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve months; and children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last at least twelve months.

Heritage Health members with SHCN will be stratified into our Care Management Risk Level 4 category and assigned a field-based care manager. Once enrolled in Care Management Risk Level 4, the member will have an assigned field-based care manager who will be actively involved in assessment, care planning, and coordination with the member's care team to prevent gaps in care, ensure that necessary services are available and in place to address immediate medical, mental health and/or behavioral needs, and serve a primary care planning point of contact for the member and his or her family. Once the critical event or disease process has been stabilized, the member may be discharged from our Care Management Risk Level 4 program (if all goals are met) or may be referred to one of our less intensive care management programs to ensure the member continues to receive access to quality and appropriate care.

Members with Co-occurring Physical and Behavioral Health Concerns

Members with co-occurring physical and behavioral health conditions are at risk for increased

hospitalizations and increased cost of care. WellCare has developed evidence-based utilization review criteria to guide both providers and concurrent reviewers to the most appropriate level of care. We minimize prior authorization requirements for most outpatient, community-based services for behavioral health and co-morbid conditions. We also continually monitor best practices and improvements in management of co-occurring conditions, and we regularly modify our criteria and guidelines to reflect these changes.

WellCare's integrated case and disease management model demonstrates our commitment to identify our members in the community, reach them where they live, understand how they prefer to engage with the health care system, facilitate their access to care, and help them when they need us. Our person-centered approach is flexible, strength-focused, family and support system-connected, continuously and reliably responsive to individual member needs, and configured to a range of available quality community resources (e.g., housing, transportation, work-relevant education, health services, recreational and spiritual resources). Case managers regularly interact with members to validate effective linkages and coordination between all providers and services as well as monitor transitions between member stratification levels including supporting our member's social service needs. We also work closely with key behavioral health and medical providers who have an interest in developing or who already have a provider based integrated, person centered model of care. Our large provider systems that have integrated health homes or medical /behavioral co-location are utilized to serve our most complex members.

Dual-eligible Members

WellCare serves 2.4 million Medicaid members and more than 350,000 Medicare Advantage members across 16 states, so the unique challenge of serving dually-eligible individuals has become a regular part of doing business for us. Among our members are those in the Dual Special Needs Populations, Fully Integrated Dual Advantage (FIDA) Aged, Blind and Disabled (ABD), Foster Children, Adults with Serious Mental Illness and Children with Serious Emotional Disturbances, individuals with Developmental Disabilities and those receiving Home and Community-Based Waiver Services (HCBS) and Long Term Supports and Services (LTSS). Because of the broad range of entities that provide coverage and services to these diverse populations, we have developed informal and formal processes for coordinating care across different payers and care coordination entities. And because we have Medicare Advantage programs as well as Medicaid programs, we have developed these processes based on best practices from both sides to ensure a seamless process for members.

Through these coordination efforts with providers and Medicare Advantage plans as well as a systematic process for coordination of benefits, we are able to monitor care provided to members who are dually eligible. Dually eligible members are flagged in our system as such, and our care managers and member services representatives can monitor for concerns about appropriateness of care.

USING DATA TO IMPROVE WELLCARE'S QUALITY OF CARE FOR VULNERABLE POPULATIONS

All of the information regarding the quality of care we provide to vulnerable populations will flow into our Nebraska-specific Quality Assessment and Performance Improvement (QAPI) governance and reporting structure, which will be overseen by our Quality Assurance and Performance Improvement Committee (QAPIC). The QAPIC reviews detailed reports include data analysis and results regarding the effectiveness of WellCare's quality of care for members with special health care needs, members with co-occurring physical and behavioral health concerns, and dual-eligible members. The QAPIC will direct and review WellCare's QAPI and utilization management activities and will have the authority to create and provide direction to work groups, committees, and departments within WellCare to assess, investigate, and take action related to the health care services received by members.

SECTION IV.M QUALITY MANAGEMENT

72. Describe the MCO's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the MCO's quality of care. *(Page limit 2 pages)*

SOLICITING FEEDBACK FROM STAKEHOLDERS TO IMPROVE QUALITY OF CARE

WellCare seeks to improve the quality of care delivered to our members by undertaking varied and innovative strategies to effectively solicit feedback and recommendations from key stakeholders, including members, families/caregivers, providers, representatives from the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) and representatives of community based organizations (CBOs) who advocate for the health and well-being of our members. Our efforts to gather feedback and recommendations from this diverse group of stakeholders will include a blend of outreach and informational activities, as described below:

- **Advisory Committees**
  - **Member Advisory Committee:** WellCare's Member Advisory Committee (MAC) will be a forum for gathering feedback from members, member representatives, providers, and community advocates that reflect the geographic, cultural and racial diversity of WellCare's population and the communities we serve. Among other responsibilities, committee participants will be invited to discuss the quality of their customer experiences with WellCare and their health care providers. Committee members will help identify root causes of barriers to receiving care as well as strategies for overcoming barriers. WellCare has effectively used the feedback from MACs to improve quality of care and plan operations. ***For example, feedback from our Hawaii MAC resulted in development of a breast cancer screening program (called "Mammo Me, Mammo You") that addressed cultural sensitivities, educated members, and resulted in significant improvement of breast cancer screening rates between 2011 and 2013.***
  - **Clinical Advisory Committee:** WellCare will convene a Clinical Advisory Committee comprised of an expert panel of Nebraska-based clinicians representing a cross-section of providers in the fields of physical health, behavioral health and pharmacy to help us ensure members receive the right care, at the right time and in the right setting. Participants will be clinicians who care for children, adolescents and adults across a variety of ages and races/ethnicities and have an awareness of differences between rural and urban populations. These clinicians will help us improve quality of care and access to services to meet Nebraska's goals for Heritage Health.
  - **Provider Advisory Committee:** WellCare will establish a Provider Advisory Committee with representation from the major provider organizations in Nebraska, individual providers, behavioral health, pharmacy providers, hospitals, and providers who primarily serve individuals with disabilities.
  - **Health*Connections* Councils:** WellCare has historically received feedback from advocates and community-based organizations (CBO) through our Health*Connections* Councils, which are community-focused planning councils that focus on issues affecting the social safety net and its viability and sustainability. We plan to implement our Health*Connections* Councils in Nebraska.
- **Satisfaction Surveys**
  - **Member Satisfaction Surveys:** WellCare uses an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) vendor that identifies a statistically valid random sample of our Medicaid and CHIP membership and annually conducts Adult and Child CAHPS surveys. The results of member satisfaction surveys have proved to be an invaluable tool for WellCare to evaluate the access and quality of care and services provided to our members and

identify opportunities for improvement.

- **Provider Satisfaction Surveys:** In order to better understand and remain well-informed about our valued provider network, we conduct annual provider satisfaction surveys. The survey concentrates on a variety of subjects, including call center/member services, provider relations, continuity/coordination of care, provider network, utilization and quality management, finance issues, pharmacy and drug benefits, and overall satisfaction and loyalty.

- **Community Outreach and Feedback:** WellCare uses a system of care approach to quality improvement that focuses on the health of the population to improve quality outcomes for our individual members. We tailor local outreach and engagement strategies based on member, provider and community partner feedback as well as research findings. This approach facilitates the cultural relevance of our efforts and ensures we address the needs of the community, including our members and their families. ***For example, between September and November of 2015, WellCare Community Relations associates already met with over 20 CBOs around the state to identify health, social, cultural and economic needs of the communities and members we will serve in Nebraska.***
- **Member and Provider Newsletters:** WellCare will produce and disseminate quarterly member- and provider-specific newsletters which will include a wealth of general and Nebraska-specific information, including how to contact WellCare to provide feedback on quality of care concerns.
- **Provider Engagement:** All of our participating providers will have access to a field-based provider relations representative who is assigned to their county and is available to conduct face-to-face visits—even on short notice—about any type of issues, such as a member's need to see a specialist quickly, the status of a prior authorization or a filed claim and correct coding for HEDIS ® measures.
- **Member Grievances and Appeals:** Complaints and grievances are closely monitored with regard to access and availability of care. When issues are identified, our Provider Relations department intervenes to re-educate the provider on their contractual obligation to adhere to standards; corrective action plans are developed if indicated.
- **Tribal Liaison:** WellCare will designate a local tribal liaison as a single point of contact to work with the Indian Health Service, tribal entities, and WellCare staff on American Indian issues and concerns.
- **Collaboration with MLTC:** WellCare of Nebraska, through representation by our medical director will participate on the MLTC Quality Management Committee. Our medical director, and as appropriate, our behavioral health clinical director and our quality management/ performance and quality improvement coordinator, will participate on any associated subcommittees.

USING STAKEHOLDER FEEDBACK TO IMPROVE WELLCARE'S QUALITY OF CARE

All of the information regarding quality of care that we gather through these outreach efforts will flow into our Quality Assessment and Performance Improvement (QAPI) governance and reporting structure, which will be overseen by our Quality Assurance and Performance Improvement Committee (QAPIC). The QAPIC reviews detailed reports including data analysis and results regarding the effectiveness of WellCare's quality of care. Clinical, member, and provider advisory committees will report, at least quarterly, to the QAPIC a summary of their QAPI-related work, recommendations, needs and activities. The QAPIC will direct and review WellCare's QAPI and utilization management activities and will have the authority to create and provide direction to work groups, committees, and departments within WellCare to assess, investigate, and take action related to the health care services received by members. It is charged with incorporating stakeholder feedback into our QAPI Program and Work Plan.

SECTION IV.M QUALITY MANAGEMENT

73. Describe the MCO's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the MCO, and how operations improved because of their results. Discuss how the MCO will collaborate with MLTC and other MCOs to conduct statewide PIPs. *(Page limit 3 pages)*

WELLCARE'S PROPOSED METHODOLOGY TO IDENTIFY, DESIGN, IMPLEMENT AND EVALUATE PIPS

In 2014, WellCare began piloting a new performance improvement project (PIP) methodology based on the ***Model for Improvement*** developed by the Associates in Process Improvement. This methodology uses rapid-cycle improvements that require a collaborative approach with cross-functional interdepartmental teams that also include network providers and external community experts. This change in approach has been well received and effective. As a result, we have begun adopting the ***Model for Improvement*** as our change process throughout the organization. WellCare's rapid cycle PIP process is broken into four phases: **identify**, **design**, **implement/test** and **evaluate**. The full process typically takes 12 to 18 months.

Identify Phase

During the *Identify* phase, we pinpoint the health outcome or area we are trying to improve and the barriers to improvement. We study current data trends and relevant research to support the quality improvement topic selection utilizing national, state, local, and historical WellCare data and industry knowledge. Data sources, such as HEDIS® and HEDIS®-like measures, member satisfaction survey data, claims and encounter data, grievance and appeal data, pharmacy data, etc., are compiled and analyzed to identify opportunities for improvement. Based on research and geographic heat-mapping (if possible), we seek to identify the members most likely to benefit from an evidence-based or best practice intervention and the likelihood of improvement based on research. We identify the types of care or services that can potentially be improved, the provider type(s) involved, and the location(s) for intervention efforts. Our PIP Steering Committee, which will be led by our medical director and report to our Quality Assessment and Performance Improvement Committee (QAPIC), will assemble an appropriate PIP team based on the topic addressed and the expertise required for success. In all cases, we include senior executives, interdisciplinary clinical staff, analytic and evaluation staff, and external partners such as providers, professional organizations, members and community based organizations depending on the scope and goals of the initiative. The PIP team develops a Global/SMART Aim goal (Specific, Measurable, Attainable, Relevant and Time-bound) that specifically identifies the study population, the desired end-state and engages in a collaborative brainstorming to identify the key drivers and root causes that influence the accomplishment of the SMART Aim. We use the combined experience and knowledge of the PIP team along with historical data and a literature review to develop a key driver diagram (KDD).

Design Phase

During the *Design* phase, our goal is to select interventions that will directly affect our ability to achieve the SMART Aim goal. To do so, the PIP team maps the current process to determine where opportunities for failure exist. Failure mode recognition includes identifying any steps in the process where there are no known procedures, existing processes that are not functioning as well as they could, or steps that do not add value. Using this systematic approach, we identify the area(s) most likely to benefit from interventions while impacting the SMART Aim. The PIP team uses WellCare's historical data and experience to decide upon the values to give to the failure effects, failure causes and priority of each step to determine a score. A Pareto Diagram is completed as a graphical display to identify the top 20 percent of factors that are leading to 80 percent of the problems and interventions are developed to target those

factors. The PIP team also chooses a data collection methodology that will enable us to answer the SMART Aim question, test interventions, and evaluate outcomes. The data collection methodology in a rapid cycle PIP must be simple, focused and provide enough data to know when improvement is occurring. We ensure that the data collected are valid and reliable by developing a data collection tool that identifies the data elements to be collected and their source, responsible team member for collecting each data element, how each data element will be collected and the frequency of collection. We establish baseline data by analyzing historical plan information to determine the benchmark for the SMART Aim question. Prior to implementation, all of PIPs will be reviewed to ensure they meet all relevant CMS requirements and are approved by MLTC.

Implement/Test Phase

We first implement the interventions on a small scale using pilot sites using a rapid cycle Plan-Do-Study-Act (PDSA) process which involves collecting data on a biweekly, semi-monthly, or monthly basis, as appropriate. If multiple interventions are implemented, each intervention is monitored sequentially, so we can determine which interventions were effective. Using a run chart, we plot and monitor progress on outcomes, process and balance measures (which help determine if there are unintended consequences) over a designated period of time as we initiate each intervention compared to our baseline and a control group (non-pilot sites).

Evaluate Phase

At the conclusion of the PIP, the PIP team identifies and summarizes key findings, determines if there was meaningful improvement, identifies and compares successful and unsuccessful interventions, lessons learned and the outcomes of the PIP. The PIP team evaluates whether the improvement can be sustained over time or if further work is needed. The PIP team determines whether further testing is needed or if the pilot should be scaled up. WellCare will submit to MLTC the results of its PIPs in its annual QAPI Program Evaluation. Next steps are also addressed in our QAPI Program Description and Work Plan.

EXAMPLES

As a national health plan, WellCare has implemented a variety of PIPs, which are informed by the collection, reporting, and analysis of administrative and clinical data. Below are just two examples of PIPs that WellCare has recently initiated that have yielded improvement in operations and quality of care for populations comparable to Heritage Health.

WellCare of Georgia: ADHD Medication Follow-Up for Children, Ages 6-12

In 2014, WellCare of Georgia conducted a PIP by partnering with three high-volume primary care providers (PCPs) to improve follow-up care for members, ages 6-12, with newly prescribed ADHD medications. The goal of the PIP was to increase treatment in order to achieve the state's benchmarks of 52.8 percent for the initiation phase and 63.1 percent for the continuation phase by December 31, 2014. Multiple operational interventions were implemented. WellCare's Quality Improvement (QI) department outreached to members via phone within seven days of initial filling of prescription in order to encourage members to attend a follow-up visit within 30 days of the initial fill. In addition, a cross-functional pharmacy and behavioral health team from WellCare conducted over 50 face-to-face visits with high-volume/ low-performing PCPs and behavioral health (BH) providers to educate them on the importance of follow-up visits. WellCare's QI BH project manager began sending lists of non-compliant members to low- performing providers in 2014 in order to determine the reasons for the lack of compliance. WellCare achieved improvements over baseline performance across both measures as shown in **Figure 8.**

Figure 8

WellCare of Georgia: ADHD Medication Follow-Up for Children					
Measure	Baseline Performance (CY2011)	Performance (CY2012)	Performance (CY2013)	Performance (CY2014)	%-Point Improvement Over Baseline
Initiation Phase Treatment	39.97%	39.39%	41.12%	48.92%	8.95
Continuation Phase Treatment	54.55%	53.10%	54.18%	63.78%	9.23

'Ohana Health Plan of Hawaii: Diabetes Care for ABD Population, Ages 18-75

WellCare's Hawaii affiliate, 'Ohana Health Plan, serves only aged, blind, or disabled Medicaid members, all of whom are considered special needs. The PIP focused on improving measures of diabetes care and included a variety of interventions over three years including development of a care gap program, so care managers could follow up and educate members and assist them with scheduling appointment with their doctor, implementation of a pay for performance quality incentive program for providers, and outreach to providers including distribution of HEDIS tool kits, and care gap reports. Improvement results are shown in **Figure 9**.

Figure 9

'Ohana Health Plan of Hawaii: Diabetes Care for ABD Population				
Measure	Baseline Performance (02/09-12/09)	Performance (CY2013)	Performance (CY2014)	%-Point Improvement Over Baseline
HbA1c testing	83.2%	88.1%	87.93%	4.73
LDL cholesterol	79.01%	83.32%	N/A*	4.31
Diabetic Retinal Exam	43.4%	63.5%	60.58%	17.18
(*) Not applicable: Measure discontinued by NCQA.				

Statewide PIP Collaboration

WellCare will support MLTC's efforts and initiatives to improve health outcomes and quality of life for all Heritage Health Members through collaboration and alignment on statewide PIPs with MLTC and other system partners. Under the leadership of our medical director, we will engage and actively participate and support collaborative working groups that include MLTC and MCO representatives to ensure alignment across interventions, data collection and analysis, and evaluation. As requested by MLTC, our medical director will participate (at MLTC's discretion) at every Quality meeting with MLTC and other system partners. We will include the statewide PIP in our annual QAPI Work Plan and Evaluation.

SECTION IV.M QUALITY MANAGEMENT

74. Discuss the MCO's approaches to annual member satisfaction surveys. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes. *(Page limit 1 page)*

WELLCARE'S APPROACH TO ANNUAL MEMBER SATISFACTION SURVEYS

WellCare uses an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) vendor that identifies a statistically valid random sample of our Medicaid and CHIP membership and annually conducts Adult and Child CAHPS surveys. We will add a collection of supplemental CAHPS items for children with chronic conditions. Samples of members 18 years of age and older and caregivers/family members of children and youth are included in all member surveys. Our vendor compiles the results, analyzes the data and provides WellCare and its affiliate health plans with a comparison of our performance against national and state benchmark standards. With oversight from our Quality Assessment and Performance Improvement Committee (QAPIC) and medical director, WellCare will use the data to evaluate how the plan is performing, identify key drivers and barriers to improvement, and develop interventions to improve Heritage Health members' experience of care with their providers and WellCare. Annually, we will submit Adult and Child CAHPS survey results and action plans derived from these results to MLTC and separate the data and results by Medicaid and CHIP populations. In addition, WellCare convenes an ongoing company-wide CAHPS work group to identify, collaborate and execute best-practice initiatives to improve members' health care and health plan experiences.

USING SURVEY RESULTS TO IMPLEMENT QUALITY IMPROVEMENTS AND IMPROVE OUTCOMES

Below are example initiatives from WellCare's Illinois affiliate health plan. **Figure 10** shows several CAHPS® Adult and Child measures which did not meet WellCare's goals for member satisfaction. As a result, WellCare conducted a barrier analysis and implemented a variety of initiatives:

- Called new members at 30 and 60 days post-enrollment to address any concerns and questions with their experience with WellCare
- Improved processes that allow members to change their PCP
- Developed and distributed a CAHPS® quick reference guide to providers
- Sent post card mailings to members that addressed access and availability concerns
- Distributed CAHPS®-like surveys at health fairs to help members understand the purpose
- Changed customer service team processes to ensure members were satisfied with their experience
- Published articles in the provider newsletter addressing ways to improve member satisfaction scores

Figure 10

EXAMPLES: ILLINOIS MEDICAID				
Measure	**Survey**	**Baseline Performance 02/14-05/14**	**Follow-up Performance 02/15-05/15**	**Percentage Point Change**
Getting Needed Care composite	Adult	69.8%	73.5%	3.7
Health Plan Rating	Adult	38.8%	58.1%	19.3
Getting Care Quickly	Child	74.8%	78.3%	3.5
How Well Doctors Communicate	Child	89.3%	93.8%	4.5

SECTION IV.M QUALITY MANAGEMENT

75. Discuss the MCO's experience with submitting HEDIS measures. Indicate whether the measures were reported for a State Medicaid, CHIP, or commercial product line. *(Page limit 1 page)*

SUBMITTING HEDIS MEASURE DATA

WellCare has over 15 years of experience submitting Healthcare Effectiveness Data and Information Set (HEDIS®) data covering our Medicaid and CHIP members to the National Committee for Quality Assurance (NCQA), CMS, and state Medicaid agencies. Our **Quality Analytics (QA)** department, a corporate unit that supports all of our state health plan affiliates, uses NCQA certified quality-measure reporting software that calculates measures using a combination of administrative and clinical (chart review) data sources and populates NCQA's Interactive Data Submission System (IDSS) templates. Once data submission files are populated, our QA department does an additional check to ensure that the information from our HEDIS software application was correctly uploaded into the system and the required measures are populated. For state specific measures, QA populates state-required reporting templates. To ensure state reporting templates are correctly populated, another team performs a secondary check of the rates and counts.

WellCare's QA team sends all NCQA IDSS files and state templates to the respective Quality department at each of our state health plan affiliates for review prior to final submission. If patient-level data files are required, QA works with WellCare's IT department to ensure that those have been uploaded timely to CMS. The Quality department for each of our state health plan affiliates is typically responsible for HEDIS data submission to their respective state Medicaid agency with support from QA. We perform a final compliance check to ensure all required deliverables are generated for each entity that receives our HEDIS data submissions. **Figure 11** summaries our experience reporting HEDIS measures for Medicaid and CHIP product lines. (Note: WellCare does not have any commercial product lines.)

Figure 11

WELLCARE HEDIS REPORTING
Product Line Experience

State	Plan Type	Enrollment	Start Year*	Number of Reportable Measures to State Agency
Florida	Medicaid (TANF, ABD), CHIP	752,000	1998	221
Georgia	Medicaid (TANF), CHIP	589,000	2008	78
Hawaii	Medicaid (TANF, ABD), Behavioral Health	48,000	2009	211
Illinois	Medicaid (TANF)	173,000	2005	78
Kentucky	Medicaid (TANF, ABD), CHIP	436,000	2013	84
Missouri	Medicaid (TANF)	107,000	2013	255
New Jersey	Medicaid (TANF, ABD, MLTSS)	60,000	2014	59
New York	Medicaid (TANF), CHIP	113,000	1994	105
South Carolina	Medicaid (TANF, ABD)	62,000	2014	62

**Start Year indicates the first year in which WellCare began submitting HEDIS data for the product line.*

SECTION IV.M QUALITY MANAGEMENT

76. Provide the MCO's vision for the MCO's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met. *(Page limit 2 pages)*

WELLCARE'S CLINICAL ADVISORY COMMITTEE

WellCare's vision for our Heritage Health Clinical Advisory Committee reflects our commitment to developing strong local partnerships with Nebraska-based clinical experts who are experienced and knowledgeable about the health care needs and barriers to access among our members. With help from local clinical experts, we will design, develop, and implement effective and appropriate practice guidelines and policies and procedures that reflect the needs of our members and drive improved health outcomes. Specifically, we will convene an expert panel of **Nebraska-based clinicians representing a cross-section of providers in the fields of physical health, behavioral health and pharmacy** to help us ensure members receive the right care, at the right time and in the right setting.

Our Clinical Advisory Committee will provide rigorous peer review and feedback on proposed practice guidelines and our Care Management (CM) and Utilization Management (UM) policies and procedures. In doing so, we envision an engaged and active Clinical Advisory Committee who will help us improve quality of care and access to services to meet Nebraska's goals for Heritage Health, such as reducing non-emergency use of the emergency department, improving birth outcomes, and integrating prevention-focused physical and behavioral health services. To this end, we will outreach to state advocacy groups, community outreach groups, social services programs and provider associations in identifying a diverse array of clinicians to serve on the committee, including primary care and specialist physicians, nurse practitioners, pharmacists, psychologists, social workers and substance use disorder specialists. We will search for individuals who are familiar with the standards and practices of treatment across urban, rural, and frontier areas of Nebraska, including diseases and chronic conditions common in the Heritage Health population, conditions affecting aged, blind, and disabled members, and mental health and/or substance use disorder treatment for adults, children and adolescents.

Clinical Advisory Committee Responsibilities

Reporting to our Quality Assessment and Performance Improvement Committee (QAPIC), the Clinical Advisory Committee will provide input into all WellCare policies, procedures, and practices associated with CM and UM functions, including clinical and practice guidelines and UM criteria to ensure that they reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in Nebraska and consistent with the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) requirements. The Clinical Advisory Committee will be responsible for the following:

- **Practice Guidelines:** Our Clinical Advisory Committee will be an important review body to help WellCare ensure that our practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. Prior to adoption by WellCare, we will ask our Clinical Advisory Committee to review and approve WellCare's initial practice guidelines and criteria as well as all significant changes to the guidelines thereafter.
- **Authorization Procedures:** WellCare will develop service authorization procedures with the input, review, and approval of the Clinical Advisory Committee. These procedures will be submitted to MLTC for review and approval, a minimum of 60 calendar days prior to the contract's start date.
- **Care Management Policies and Procedures:** With the input, review, and approval of the Clinical Advisory Committee, WellCare will annually review and update, as necessary, our CM policies and procedures. Once they are approved by the Clinical Advisory Committee, we will submit any proposed changes to MLTC for review and approval a minimum of 60 calendar days prior to intended

implementation.

- **QAPIC Reporting:** At least quarterly, the Clinical Practice Committee will report to the QAPIC and provide a summary of its work, concerns, recommendations, and activities.

Representation on the Clinical Advisory Committee

WellCare's Clinical Advisory Committee will be comprised of WellCare of Nebraska's medical director and individuals who care for children, adolescents and adults in Nebraska across a variety of ages and races/ethnicities, have an awareness of differences between urban, rural, and frontier populations and represent pharmacists, physical health providers, and behavioral health providers. Potential participants may be nominated by members of our Care Management department or providers can nominate themselves or peers. Information about the Clinical Advisory Committee will be available on WellCare's provider portal, in the provider handbook and in the provider newsletter. Providers may submit their nomination online or send an email to their provider relations representative to express interest in serving or to nominate another provider. Each nomination will be considered by the Utilization Management Committee (UMC). Every quarter, the UMC will review nominations for additions to the Clinical Advisory Committee as needed. The criteria considered will include provider geographic location (i.e. urban, rural, frontier), provider type (including pharmacists, physical health providers and behavioral health providers) and volume of WellCare membership in the provider's practice. The UMC will vote to accept or reject the nomination, and the nominee will be notified of the result by his or her provider relations representative. Participants will be time-limited up to two years but may reapply.

Clinical Advisory Committee Plan

WellCare will develop a Clinical Advisory Committee Plan that describes the committee's authority, scope, membership, staff support, and meeting frequency. We will submit our draft Clinical Advisory Committee Plan to MLTC for approval a minimum of 60 calendar days in advance of the committee's establishment.

Meeting Location, Frequency and Reporting

WellCare's Clinical Advisory Committee will meet quarterly. All committee participants will be reimbursed for time and travel costs. The locations of all meetings will be held in accessible facilities and refreshments will be provided. Additionally, we will invite participants to attend via webcast or by a toll-free teleconference line if that is their preference. Interpretation services will be available and we will make accommodations for individuals with communication support needs. Meeting minutes will be documented and reviewed/approved by committee members at the next meeting. Once approved, WellCare will provide copies of committee minutes to MLTC.

Collaboration with Behavioral Health Providers in Developing Guidelines

Example: WellCare of Kentucky

During 2013, providers from the WellCare of Kentucky's Behavioral Health Clinical Advisory Council participated with WellCare's Behavioral Health leadership team to develop a Clinical Care Guideline for the treatment of juvenile sexual offenders in Kentucky. As a result of network provider feedback, WellCare of Kentucky determined that applying evidenced-based national guidelines to the treatment of sexually reactive children for a sub-acute residential program in Kentucky was not effective. Ultimately, the project committee successfully developed an evidenced-based clinical care guideline to be used for initial and concurrent reviews to determine the medical necessity of residential treatment for youthful sexually reactive members. The guideline was approved by the Kentucky Department for Medicaid Services and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities.

SECTION IV.M QUALITY MANAGEMENT

77. Describe the MCO's practice of profiling the quality of care delivered by PCPs, specialists, and hospitals, including the methodology for determining which and how many providers will be profiled.

- Submit sample quality reports.
- Describe the rationale for selected the measures that are gathered/reported.
- Describe the proposed frequency of profiling activities.

(Page limit 3 pages, excluding sample quality reports)

PROVIDER PROFILING: IMPROVING OUTCOMES THROUGH ANALYTICS AND TECHNICAL ASSISTANCE

Provider quality of care measures are meant to collectively make care safe, timely, effective, affordable, and member-centered. To that end, WellCare uses provider profiling reports to increase provider awareness of performance, motivate providers to achieve measurable goals, identify best practices and improvement opportunities for providers, and facilitate collaboration in the development of clinical improvement initiatives. In doing so, we select measures that are based on nationally accepted measure sets, are recognized as clinically important, and are grounded in empirical evidence that demonstrates the measure provides stable and reliable information. We leverage our locally based provider relations representatives and our Clinical HEDIS® Practice Advisors (CHPAs) who routinely meet with providers to deliver profile reports and provide education and technical assistance in identifying opportunities and strategies for improving the quality of member care and reducing costs.

In the following response, we describe our experience and planned approach for profiling the quality of care delivered by Heritage Health primary care providers (PCPs), specialists and hospitals, including the methodology for determining which and how many providers will be profiled, the rationale for selected measures, and the proposed frequency of profiling activities. Additionally, we have included **Attachment 77a_FL Care Gap Report Example** and **Attachment 77b_OH Care Gap Report Example** to provide examples of quality reports we currently use.

Primary Care Providers

WellCare profiles PCPs by assessing their quality, cost and utilization performance. A Provider Profile that addresses HEDIS care gaps is prepared for each of our PCPs that care for a high volume of our membership in a state. Our local provider relations representatives and Clinical HEDIS® Practice Advisors (CHPAs) meet onsite with these high-volume network providers and their office teams, to deliver and review the Provider Profile reports and provide education and HEDIS technical assistance in identifying opportunities and strategies for improving the quality of member care and reducing costs. They review the Provider Profile with the PCP to identify areas of excellence and opportunities for improvement, as measured by HEDIS®, as compared to their peers as well as state and national benchmarks if available. Reports also include measures of inpatient, outpatient, emergency department utilization and costs, which can be rolled up and compared across physicians or at the physician group level. A report includes the PCP's compliance rate for HEDIS® measures that can be impacted by a PCP at the provider level. The report identifies members with a gap in care, such as a missed immunization or well-child visit. We provide regular on-site assistance to these providers, and ad hoc assistance via email or conference calls to strategize solutions to complex clinical issues and work towards resolution of HEDIS® deficiencies. We track the success of our interactions with the providers in closing gaps in member care by reviewing the data every month to determine compliant HEDIS® measures.

In order to enhance the support we offer our providers, WellCare is working to automate production and expand functionality of our Provider Profiles. We are building new reporting tools that will increase

utility and improved efficiency. Our expanded Provider Profile reports will include a greater emphasis on episodic, condition-specific reports. Episodic reporting will allow us to measure efficiency and effectiveness within a specified period of time, including gaps in care. The reports will integrate clinical and administrative (e.g. pharmacy, behavioral health, and medical claims) data to identify rates of gaps in care delivery, the average cost of care by episode, and measures of cost and quality performance.

WellCare's Quality Assessment and Performance Improvement Committee (QAPIC) will select Provider Profile measures to align with the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) Quality Strategy, including the PCP-influenced performance measures included in Attachment 7 of the Heritage Health MCO Request for Proposals (RFP). WellCare will also place a priority on selecting Provider Profile measures that are tied to our QAPI Program, performance improvement projects (PIPs), and other measures of cost, efficiency, and utilization of services such as non-emergent use of the emergency department, inpatient physical and behavioral health admissions and readmissions, and ambulatory care sensitive admissions.

Specialist Providers

Working in partnership with WellCare's Medical Economic department, several of WellCare's state health plans have experience developing and distributing risk-adjusted specialist Provider Profiles that analyze utilization rates such as visits, unit cost, and claims payments against state Medicaid and Medicare rates. The analyses are used to help specialists and our associates understand our operations and utilization patterns in order to address variation. The new tools that we are building to support PCP profiling, including quality and efficiency episodic reports, will also support our specialist providers. The output will allow specialists to compare practice patterns to determine if their efficiency is above or below specialty peers.

A Provider Profile will be prepared for WellCare's Heritage Health specialist providers that provide a significant proportion of visits within a given specialty per year. WellCare's QAPIC will select specialty specific measures based on MLTC's Quality Strategy, our QAPI Program, and planned PIPs.

Quality measures will be determined based on the extent to which the specialist has influence over performance on the measure. For example, obstetricians will receive provider profiles that include measures such as: live births weighing less than 2,500 grams (LBW), frequency of ongoing prenatal care (FPC), timeliness of prenatal Care (PPC), and behavioral health risk assessment (for Pregnant Women) (BHRA).

Hospitals

WellCare will develop Provider Profiles that are specific to Heritage Health hospitals in our network that serve a significant percentage of our inpatient admissions or outpatient visits. WellCare's QAPIC select profile measures based on MLTC's Quality Strategy, our QAPI goals, and each hospital's specific service lines. Hospital Provider Profiles may include such measures as inpatient mortality, ambulatory care sensitive admissions, readmissions, non-emergent use of the emergency department, follow-up after hospitalization by a PCP, follow-up after hospital for mental illness, and in-hospital complications and adverse events following surgeries, procedures, and childbirth. These data will provide a mix of insights about care within the hospital as well as insight into the community health care system and services outside the hospital setting.

Figure 12 summarizes WellCare's proposed approach to profiling the quality of care delivered by PCPs, specialists, and hospitals in Nebraska.

Figure 12

WellCare of Nebraska: Proposed Approach to Provider Profiling			
Profiling Reports			
Proposed Approach	**PCPs**	**Specialists**	**Hospitals**
Methodology for determining which and how many providers will be profiled	PCPs that care for a high volume of WellCare's Heritage Health membership	Specialists that provide a significant percent of WellCare visits within a given specialty per year	Hospitals that care for a significant percent of our inpatient admissions or outpatient visits
Rationale for selected measures	Based on MLTC Quality Strategy, measures included Attachment 7 of the Heritage Health MCO, WellCare QAPI Program, and PIPs	Based on MLTC Quality Strategy, measures included Attachment 7 of the Heritage Health MCO, WellCare QAPI Program, PIPs, and specialty specific quality of care measures	Based on MLTC Quality Strategy, WellCare QAPI Program, PIPs, and hospital-specific service lines
Proposed frequency of profiling activities	HEDIS reports: Monthly Episodic reports: At least every 6 months	HEDIS reports: Monthly Episodic reports: At least every 6 months	At least annually

Sample Quality Reports

See **Attachment 77a_FL Care Gap Report Example** and **Attachment 77b_OH Care Gap Report Example** for samples of WellCare's existing quality reports.

Provider Rates

Claims/Encounters Received Thru 08/31/2015

	HEDIS 2016 CURRENT RATE				NCQA PERCENTILES		ADDITIONAL COMPLIANT MEMBERS TO REACH	
MEASURE	ELIGIBLE MEMBERS	COMPLIANT MEMBERS	RATE	PERCENTILE MET	75TH	90TH	75TH	90TH
Adolescent Well Visit	10	3	30.00%		59.98%	66.58%	3	4
App Tx for URI	1	1	100.00%	90th	92.51%	95.17%	MET	MET
Child BMI Percentile	15	0	0.00%	<25th	77.98%	85.61%	12	13
Nutrition Counseling	15	1	6.67%	<25th	72.87%	79.56%	10	11
Physical Activity Counseling	15	1	6.67%	<25th	64.43%	71.53%	9	10
Preventive Visit (12-19 yrs)	3	3	100.00%	90th	92.46%	94.91%	MET	MET
Preventive Visit (25m-6 yrs)	2	2	100.00%	90th	91.22%	92.93%	MET	MET
Preventive Visit (7 - 11 yrs)	2	1	50.00%	<25th	93.90%	95.88%	1	1
Strept Test For Pharyngitis	2	0	0.00%	<25th	79.83%	85.25%	2	2
Well Child 3-6 yo Visit	1	1	100.00%	90th	78.46%	83.75%	MET	MET

SAMPLE

WellCare of Florida, Healthy
Healthy Kids
Claims/Encounters Received Thru 08/31/2015

MEMBER NAME	SUBSCRIBER	DATE OF BIRTH	PHONE	MEASURE	DATE NEEDED BY
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Adolescent Well Visit	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Strept Test For Pharyngitis	10/31/2014
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Adolescent Well Visit	12/31/2015
				Adolescent Well Visit	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Preventive Visit (7 - 11 yrs)	12/31/2015
				Adolescent Well Visit	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Strept Test For Pharyngitis	06/07/2015
				Adolescent Well Visit	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Adolescent Well Visit	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Child BMI Percentile	12/31/2015
				Nutrition Counseling	12/31/2015
				Physical Activity Counseling	12/31/2015
				Adolescent Well Visit	12/31/2015

SAMPLE

Overall IPA Rates

Claims/Encounters Received Thru 08/31/2015

	HEDIS 2016 CURRENT RATE				NCQA PERCENTILES		ADDITIONAL COMPLIANT MEMBERS TO REACH	
MEASURE	ELIGIBLE MEMBERS	COMPLIANT MEMBERS	RATE	PERCENTILE MET	75TH	90TH	75TH	90TH
Adult BMI Percentile/Value	3	2	66.67%	<25th	89.62%	92.94%	1	1
Adult Preventive Visit	21	20	95.2[illegible]	90th	86.91%	88.75%	MET	MET
Anti-Rheumatic Drug	2	2	100.00%	[illegible]	75.71%	82.04%	MET	MET
Antidepressant Mgmt Acute Phase	1	0	0.00%	<25th	56.15%	62.56%	1	1
Antidepressant Mgmt Cont Phase	1	0	0.00%	<25th	40.48%	48.39%	1	1
Diabetes - Dilated Eye Exam	2	1	50.00%	25th	63.23%	67.74%	1	1
Diabetes HbA1c < 8	2	0	0.00%	<25th	54.01%	58.58%	2	2
Diabetes HbA1c <= 9	2	0	0.00%	<25th	65.34%	70.32%	2	2
Diabetes HbA1c Test	2	2	100.00%	90th	89.55%	91.94%	MET	MET
Diabetes Monitor Nephropathy	2	2	100.00%	90th	84.88%	87.70%	MET	MET
Mammogram	2	2	100.00%	90th	66.02%	71.41%	MET	MET
Pap Test	1	1	100.00%	90th	67.88%	73.08%	MET	MET

SAMPLE

Care Gaps
Claims/Encounter Received Thru 08/31/2015

PROVIDER ID	PROVIDER NAME	MEMBER NAME	SUBSCRIBER	DATE OF BIRTH	PHONE	MEASURE	DATE NEEDED BY
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Adult Preventive Visit	12/31/2015
						Adult BMI Percentile/Value	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Antidepressant Mgmt Acute Phase	09/06/2014
						Antidepressant Mgmt Cont Phase	01/01/2015
						Diabetes - Dilated Eye Exam	12/31/2015
						Diabetes BP < 140/90	12/31/2015
						Diabetes HbA1c < 8	12/31/2015
						Diabetes HbA1c <= 9	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015
						Diabetes BP < 140/90	12/31/2015
						Diabetes HbA1c < 8	12/31/2015
						Diabetes HbA1c <= 9	12/31/2015
						Hypertension	12/31/2015
						Hypertension	12/31/2015

SAMPLE

SECTION IV.M QUALITY MANAGEMENT

78. How will the MCO use the Member Advisory Committee to improve quality of care and direct quality and operational changes? What representation does the MCO plan to have on each committee (e.g., stakeholder types, from what geographic areas)? How will the MCO identify participants of the Member Advisory Committees? Provide examples from other states where the MCO has collaborated with members for program improvement. *(Page limit 5 pages)*

WellCare seeks to improve the health of our members and promote a patient-centered delivery system by building effective partnerships with the people we serve as well as our provider network and state and local advocates. We will leverage our experience convening member and provider advisory groups in other states to effectively solicit a diverse array of member and stakeholder feedback through a Nebraska-based Member Advisory Committee (MAC). The committee will provide a regular forum for our associates to learn about member needs, satisfaction, and quality of care. The feedback will drive our quality improvement strategies and provide an interactive venue to collaborate on enhancements to our programs and processes and create responsive changes that help us to better serve our Heritage Health members.

USING WELLCARE'S MEMBER ADVISORY COMMITTEE TO IMPROVE QUALITY AND OPERATIONS

Role of the Member Advisory Committee: Engagement

WellCare's Member Advisory Committee will be a forum for gathering feedback from members, members' representatives, providers, and advocates that reflect the diversity of WellCare's population and the communities we serve. The committee will be accountable to WellCare of Nebraska's Board of Directors and will serve as an important feedback loop for our Quality Assurance and Performance Improvement Committee (QAPIC), which has oversight of our quality improvement goals, Quality Assessment and Performance Improvement (QAPI) Work Plan, improvement projects, performance targets, and evaluation. Specifically, the Member Advisory Committee will provide input into the following areas:

- **Planning and Delivery of Services:** Committee members will be invited to discuss the quality of their customer experiences with WellCare and health care providers and help us identify root causes of barriers to receiving care as well as potential strategies for overcoming barriers. We will present the committee with data to show where and how members access care help us identify any gaps. We will also seek feedback on our efforts to coordinate and integrate prevention-focused physical and behavioral health services.
- **Quality Management and Quality Improvement Activities:** The Member Advisory Committee will discuss and provide feedback on the results of Consumer Assessment of Health Care Provider and Systems Survey (CAHPS®). They will also help us develop appropriate quality improvement projects and interventions.
- **Program Monitoring and Evaluation:** The committee will help us design, develop, and interpret the results of our program monitoring and evaluation efforts. Reports and documentation will be made available prior to the meetings, so participants can review and engage in productive dialog.
- **Member, Family and Provider Education**: WellCare will use the Member Advisory Committee to review and seek feedback on our outreach materials and processes, including our Member Handbook, website, member portal, newsletters, social media and other communication tools. We will seek input to ensure our materials are culturally competent, understandable and fully accessible, and address our members' health education and literacy needs and concerns.
- **Community Collaboration**: Participants will provide input and feedback on how we collaborate and communicate with community organizations regarding services and benefits.

Input we gather from the Member Advisory Committee will be invaluable in helping us shape improvements to programs, operations and quality of service. The committee's ideas and perspectives will be used to inform member outreach efforts, coordination with Heritage Health carve-out benefits, and other health and social services that require coordination improvements and have an impact on members' health and well-being. Feedback and suggestions from the Member Advisory Committee will be incorporated into our programs and policies through the QAPIC. The QAPIC directs and reviews WellCare's QAPI and Utilization Management activities, and has the authority to create and provide direction to work groups, committees, and departments within the health plan to assess, investigate, and take action related to the health care services received by members.

Information and insights gathered from the Member Advisory Committee will also be shared with members and providers through our website, member and provider newsletters and other forms of communication including our digital media strategies (i.e. Facebook, Twitter).

Member Advisory Committee Plan

Each year, WellCare will develop and implement a Member Advisory Committee Plan that describes the meeting schedule and the draft goals of the committee. Goals will include soliciting and understanding members' perspectives about improving the planning and delivery of services, quality of care, member satisfaction, member education and outreach, and community collaboration. We will submit our draft Member Advisory Committee Plan to MLTC for approval a minimum of 60 calendar days before the contract start date and annually thereafter.

Meeting Location and Frequency

WellCare's Member Advisory Committee will meet quarterly at rotating locations around Nebraska. We have implemented this rotating model in other states where participants often need to travel long distances to attend. This helps distribute the time commitment associated with travel. All MAC participants will be reimbursed for any travel costs. The locations of all meetings will be held in accessible facilities and refreshments will be provided. We will also offer transportation and attendant care services for members and members' representatives, if needed. Additionally, we will invite participants to attend via webcast or by a toll-free teleconference line if that is their preference. We will assist participants identify Internet access and webcast equipment by partnering with a local library, community action agency, or other community based organizations that may be able to provide the service. As necessary, we will also equip our geographically dispersed Welcome Rooms, which can also serve as convenient webcast sites. Interpretation services will be available and we will make accommodations for individuals with communication support needs.

Record Keeping and Reporting

Meeting minutes will be documented, reviewed and approved by committee participants at the next meeting. WellCare will report to MLTC on the activities of our MAC semi-annually. Our report will include the membership of the committee (name, address, and organization represented), a description of orientation and ongoing training activities for committee participants, and information about committee meetings, including the date, time, location, meeting attendees, and minutes from each meeting. WellCare will copy MLTC on all correspondence to the committee, including agendas and committee minutes. Minutes will include action items, status updates, and outcomes of the committee's initiatives.

REPRESENTATION ON MEMBER ADVISORY COMMITTEE

WellCare's Member Advisory Committee will include members, members' representatives, providers, and advocates that reflect WellCare's population and communities served. Our member selection process will focus on identifying a diversity of member perspectives, including members who live in different geographies (e.g. urban, rural, frontier), come from different cultural, ethnic, or tribal backgrounds, and who have varying levels of experience as WellCare members. We will seek representation from

transition-aged foster children, consumers with behavioral health conditions, members who are aged, blind or disabled, caregivers, and guardians of children with special health care needs. Committee membership is active for a period of one calendar year and is a voluntary duty. All MAC representatives receive a free gift for attending, which is typically a nominal gift card to a local restaurant.

IDENTIFYING MEMBER ADVISORY COMMITTEE PARTICIPANTS

WellCare will implement different strategies to identify Member Advisory Committee participants depending on whether we seek individuals who represent members and members' representatives, providers, or advocates. These processes are described below:

Members and Members' Representatives

Members and members' representatives will be chosen to participate on the MAC through a nomination and selection process. Potential MAC participants can be nominated by WellCare associates who interact most with members, including our case managers, member outreach personnel and community relations teams. Members may also be nominated by providers and advocates. We have recently expanded our MAC nomination process by educating members and members' representatives about the committee and encouraging self-nomination for members who would like to serve. We also use robust communication strategies that will include our website, member materials, internal communications and community events so staff can nominate members. Our Member Services staff will outreach to underserved groups representing the geographic, cultural, and racial diversity of our membership. We will outreach to state advocacy groups, community outreach groups, social services programs and provider associations in identifying a diverse array of participants to serve on the committee.

WellCare's MAC application will be available on our website, in the Member Handbook and at community events. Members and members' representatives can request an application by calling Member Services or they can request one from their case manager. Individuals who wish to participate on the MAC will complete an application and submit it by mail, fax, or online to our Member Outreach team. Applications are reviewed by the Member Advisory Oversight Committee, an internal cross-departmental committee, and selected participants are notified by telephone or mail that they have been selected to participate in the MAC.

Providers

Provider participants that will serve on the MAC will also be chosen through a nomination and selection process. Potential provider participants can be nominated by members of our Provider Relations team or providers can nominate themselves or peers. Information about the MAC will be available on WellCare's provider portal, in the Provider Handbook and in the Provider Newsletter. Providers may email their provider relations representative to express interest in serving on the MAC or to nominate another provider. The Provider Service team will also be able to refer interested providers to their provider relations representatives.

Each nomination will be considered by an internal, cross- departmental committee that includes our medical director, Network Management leadership, a quality representative, a health services representative and a behavioral health representative. Every quarter, the committee will review nominations for additions to the MAC as needed. The criteria considered will include provider geographic location (i.e. urban, rural, frontier), provider type (emphasis on primary care providers (PCPs) and pediatricians), and volume of WellCare membership in the provider's practice. The committee will vote to accept or reject the nomination, and the nominee will be notified of the result by his or her provider relations representative.

Advocates

WellCare has historically received feedback from advocates and community-based organizations (CBO) through our Health*Connections* Councils, which are community-focused planning councils that focus on

issues affecting the social safety net and its viability and sustainability. While we plan to implement our Health*Connections* Councils in Nebraska, we are expanding our MAC model to include advocates and CBO representatives. We will select advocates and CBO representatives who do not contract with us to provide covered services, but who are important to the health and well-being of our members. CBO organizations that we expect may participate on MAC include the Crisis Center, which has provided advocacy to the survivors of domestic violence and sexual assault for over thirty years in Central Nebraska, the Nebraska Children and Families Foundation, Community Action Agencies, Appleseed, and Voices for Children in Nebraska. CBO representatives who wish to participate in the MAC complete an application and submit it via fax, mail, or online to the Member Outreach team. The applications are reviewed by an internal committee and CBO representatives are notified by telephone or mail writing that they have been selected to participate in the MAC.

Participant Orientation and Training

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

EXAMPLES FROM OTHER STATES

WellCare's affiliate plans in other states have effectively used the feedback from Member Advisory Committees to improve quality of care and plan operations.

Hawai'i: 'Ohana Health Plan

Our affiliate in Hawai'i, 'Ohana Health Plan, used feedback from its MAC to design a program to increase breast cancer screenings. Cultural sensitivities and discomfort had made it difficult for many women to seek out mammograms, and the MAC feedback brought that to light. The resulting "Mammo Me, Mammo You" Program to Increase Breast Cancer Screenings is operated in partnership with Queen's Medical Center's Women's Health Center. The purpose of the program is to educate members on the importance of breast cancer screenings, alleviate any fears they may have, and assist in scheduling a mammogram. One day a month is designated at Queen's Medical Center Women's Health Center for 'Ohana members to come in and receive education on breast cancer screenings, instruction on how to perform self-exams, and have a mammogram performed in a relaxing atmosphere. Initial success of this initiative led 'Ohana to perform further data analysis on member demographics to identify the area of the state with the largest volume of members with breast cancer screening care gaps and to expand the program. 'Ohana's HEDIS® rate for the Breast Cancer Screening measure subsequently increased, showing significant improvement between 2011 and 2013.

WellCare's Proactive Outreach

"After meeting with WellCare and learning more about how the organization supports its members, their families and the community-at-large, I would like to extend Nebraska Children and Families Foundation's support for WellCare's bid submission."

Jennifer Thielen
Associate Vice President of Strategic Partnerships
Nebraska Children and Families Foundation

WellCare of Georgia

WellCare of Georgia and the state's Department of Community Health (DCH) share the priority of increasing primary care services to improve health outcomes and decrease emergency department utilization. In 2014, WellCare asked MAC representatives how it could better educate members about the importance of a PCP and establishing a medical home. The members recommended WellCare conduct member orientations to educate members on:

- The roles, responsibilities and benefits of a medical home
- The role of a PCP

- How to get the most out of their coverage

In response, WellCare developed a strategy to implement member orientations throughout Georgia. We developed a presentation that addresses the topics suggested by the MAC and use our Community Outreach team to facilitate the orientation sessions for members. Community Outreach and Member Retention staff coordinate and facilitate local sessions in locations throughout the state. We assess effectiveness of the education by conducting exit surveys and compiling real-time feedback. We also asked our Georgia members what more we could do to encourage them to receive necessary preventive services. Giving gift cards to members who receive the recommended services was a very popular recommendation. As a result, we developed our Healthy Rewards Program, and conducted a pilot of the program in 2014. Based on the success of the pilot, we are re-launching the Healthy Rewards Program, and will reward members who complete specific preventive health, wellness and engagement milestones with a Healthy Rewards reloadable debit card. Members will receive the debit card upon completion of their health risk assessment, a PCP visit within their first 90 days of enrollment, and key screenings and immunizations.

SECTION IV.M QUALITY MANAGEMENT

79. Describe the information the MCO will provide to members and providers about the QAPI program. *(Page limit 2 pages)*

ENGAGING MEMBERS AND PROVIDERS ON WELLCARE'S QAPI PROGRAM

WellCare seeks to improve the health of our members by engaging members and providers in achieving the goals of our Quality Assessment and Performance Improvement (QAPI) Program. To achieve this goal, WellCare pursues proactive education, outreach, follow-up, and incentives delivered through a variety of channels targeting members and providers. These engagement efforts drive our quality improvement strategies and provide opportunities for members and providers to help us continually improve and refine our QAPI efforts in response to changing needs, as further described below:

Communicating QAPI Information to Members

WellCare employs multiple mechanisms specifically designed to help members understand our QAPI Program and empower them to navigate the health care system and improve their health. Member education regarding our QAPI Program begins when the member joins WellCare and continues for as long as she or he is enrolled with us. It extends beyond the distribution of required information to include both broad-based and targeted outreach campaigns, as described below:

- **Welcome Call:** All new members, including reinstated members, are automatically scheduled for a welcome call within 15 business days of the date we send a welcome packet. The welcome call is our first opportunity to engage and educate members on our QAPI-related goals. The calls include a health risk screening (HRS) to identify health conditions, pregnancy, or the need for care coordination services. Before completion of the HRS, the member is given the opportunity to be transferred to a Member Service associate to discuss any health issues of concern or to have any other questions answered.
- **Member Newsletter:** Our quarterly newsletters educate members on a variety of health, wellness, benefits and requirements of the plan including helpful suggestions for self-care, stress management, and brief screening tools for problems such as depression or substance use disorders. WellCare uses its newsletters as an outreach tool to inform members of our ongoing QAPI goals, efforts, and performance improvement projects.
- **Member Handbook:** Our new member packet contains information on a variety of QAPI-related topics including information about preventive health guidelines and recommended screenings, diagnostic and immunization schedules.
- **Healthy Rewards:** WellCare's Healthy Rewards Program rewards members who complete specific preventive health, wellness and engagement milestones with a reloadable Healthy Rewards debit card. Specific Healthy Rewards activities and services with incentives are an outgrowth of our QAPI Program. The Healthy Rewards debit card is credited with dollars upon completion of specific activities and services. Members receive information on our Healthy Rewards Program through the Welcome Call and Member Handbook.
- **Digital Media:** We also outreach to our members through our secure member web portal, Facebook, Twitter and YouTube. Through these channels, we regularly communicate information regarding QAPI Program efforts and ways to empower members in their own health outcomes.
- **Welcome Rooms:** Our Welcome Rooms, strategically located in neighborhoods and communities where members live, work, and frequent, are equipped to function as outreach centers and walk-in member service hubs. Here members and families can meet face-to-face with a WellCare associate and receive personalized attention to their needs. Ongoing QAPI education will be available through monthly classes. At least one daytime and one evening class will be held per month. Our welcome

rooms will provide an ideal opportunity for members to learn more about the Heritage Health Plan and receive information on important health topics.

- **Mobile Device Application:** Our mobile application for smartphones and mobile devices, "MyWellCare," provides friendly, timely alerts when members are due for wellness services or checkups. The application enables us to send messages to members about important, time relevant QAPI-related items – like reminders about flu shots and wellness visits.
- **Health Fairs:** WellCare's Community Relations staff will attend and participate in health-focused events to share information, resources and education concerning a variety of QAPI health topics such as diabetes management, back-to-school health, the importance of physical activity and general overall health and well-being.
- **EPSDT Periodicity Letters:** Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) periodicity letters will be mailed to children from birth to age 21 on their birthday month with a reminder of age appropriate preventive care services.

Communicating QAPI Information to Providers

Upon joining our network, WellCare's providers and their office staff are educated about our QAPI Program and their roles and responsibilities with respect to access and quality of care standards. We also provide ongoing provider education and training, including 60 days prior to the start of any new program, PIP, or service. Most training includes a review of provider responsibilities and the provider requirements regarding supervision and coordination of care for members. Outreach efforts include the following:

- **Provider Newsletter:** We will distribute a Nebraska-specific quarterly newsletter to participating providers addressing a wide variety of QAPI topics, including annual QAPI goals, measures, and performance improvement projects.
- **Provider Manual:** Our provider manual is available in hard copy, digital and web-based formats. We update it annually to include a description of our QAPI Program, quality of care measures, and performance improvement projects.
- **Provider Website/Portal:** Our secured environment for the provider website, requiring login and password credentials, gives our providers an opportunity to access various easy-to-use tools to obtain QAPI-related information, clinical practice guidelines, and perform day-to-day tasks. It includes member-level information about specific screenings, immunizations and overdue services. It also includes an Interactive HEDIS Online Portal Training module to facilitate provider education.
- **Clinical HEDIS Practice Advisors:** Our Nebraska-based Clinical HEDIS Practice Advisors (CHPAs) are dedicated staff who delivers education and consultation to providers and provider practice sites on a number of QAPI preventive and chronic health management measures including immunizations and well-child/well-care checks. They assist provider offices with barrier analysis and developing strategies to improve compliance within the practice.
- **Provider Care Gap Reports:** Provider Care Gaps Reports are an internal web based tool that can be used by associates to help identify member gaps in care. Clinical HEDIS Practice Advisors (CHPAs) and Provider Relations (PR) Representatives use the care gap reports to help provide education and outreach to provider offices in an effort to ensure members are receiving the preventive services they need. Provider Care Gaps Reports have been in use at WellCare since 2007 for provider educational purposes. Providers can use the care gap reports shared with them by WellCare associates in conjunction with the provider portal to identify and close individual member care gaps.

SECTION IV.N UTILIZATION MANAGEMENT

80. Describe the MCO's approach to utilization management, including

- Innovations and automation the MCO will use for its UM program.
- Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers.
- Mechanisms to detect and document over- and under-utilization of medical services.
- Processes and resources used to develop and regularly review utilization review criteria.
- How the MCO will use its UM Committee to support UM activities.

(Page limit 5 pages)

HELPING MEMBERS GET THE MOST APPROPRIATE CARE: WELLCARE'S APPROACH TO UTILIZATION MANAGEMENT

WellCare's extensive conversations in Nebraska have made clear that the State is serious about changing health care for the better for Nebraskans. The effort through Legislative Resolution (LR) 22/422 illustrates the State's forward-thinking approach to health care transformation and the eight building blocks emerging from the LR22/422 work group provide a useful roadmap for Medicaid managed care organizations like WellCare. As a managed care organization with more than 20 years of experience providing utilization management (UM) services for Medicaid enrollees, we are confident in our ability to advance the State's priorities and support achievement of the eight building blocks.

Our UM program is designed to serve Medicaid members across a variety of program categories and reflects Medicaid members' unique circumstances, often including a highly-complex and diverse combination of medical, behavioral, and socio-economic needs. Our UM activities have several key components, including, but not limited to the following areas:

- Evaluation of medical necessity of health care services according to established criteria and practice guidelines to ensure that the right amount of services are provided to members when they need them
- A focus on individual and system outliers to assess if individual members are meeting their health care goals and if service utilization across the system is meeting the goals for delivery of community-based services
- Compliance with Federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 438
- Requirements for inpatient hospital providers to comply with Federal requirements regarding UM plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 CFR 44, 455 and 456
- Strict processes to ensure our program does not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member, as described in 42 CFR 210(e)
- Active monitoring of Federal and State Medicaid regulations for updates and changes
- Monitoring of all UM activities for compliance with Federal and State Medicaid regulations

Our fully integrated member-centered UM program assesses needs on a case-by-case basis to ensure every member has the opportunity to receive the most effective and appropriate services in the least restrictive settings of their choice. Serving millions of Medicaid members across the country, we have built our UM framework on six guiding principles (outlined below) that are integrated within and

reinforced throughout our systems, processes, policies and staffing.

- **Effective:** The criteria and processes by which we evaluate requests for services are based on current scientific, evidenced-based guidelines with proven results in improving clinical outcomes
- **Safe:** We manage and coordinate utilization of services with an aim of connecting members to care which is helpful and not harmful
- **Timely:** We aim to prevent unintended delays, and we monitor our staff and processes to ensure accessibility and promptness consistent with our members' health needs
- **Efficient:** We seek to reduce waste by creating value, monitoring health outcomes relative to cost, and minimizing errors. We also continually apply process improvement methodologies
- **Equitable:** We establish safeguards to assure that our members, regardless of diagnosis, race, age, ethnicity, primary language or socioeconomic status, receive appropriate, high quality care
- **Person-Centered:** We connect members with culturally, socially and linguistically-appropriate physical and behavioral health care that empowers health care decision-making accountability

INNOVATIONS AND AUTOMATION: THE FOUNDATIONS OF WELLCARE'S UM PROGRAM

Our UM programs feature an array of innovations and automation, each reinforcing one or more of the pillars identified above. Highlights from our UM program include:

- **WellCare's Medical Management Platform (MMP):** Our MMP is a fully-integrated system that supports the evaluation of medical and behavioral service requests to ensure they are appropriate and medically necessary. As a person-centered platform, it enables care integration and continuity of care among all places of service and levels of care and provides a 360-degree view of our members including member demographics, provider assignments, care gaps, actual cost of care, and medical, behavioral health, pharmacy and lab utilization. Our MMP features automatic data integration from our web-based authorization tool and enables us to:
  - Maintain a comprehensive health record for all medical, behavioral and pharmacy claims
  - Create and maintain comprehensive discharge plans, including extending the discharge plan to key providers and care managers, where applicable
  - Manage authorizations and utilization
  - Support safe, efficient transition of members across levels of care
- **WellCare's Proprietary Drug Evaluation Review (DER) Workflow System:** WellCare has made significant investments in pharmacy prior authorization technology and processes, including our proprietary, role- and task-based Drug Evaluation Review (DER) workflow system. The systems and processes allow us to track and process DER requests, including prior authorizations and formulary exceptions, in a timely manner and in accordance with contract requirements.
- **WellCare's Gold Card Program:** We are evolving our UM program toward a shared-decision support model with our contracted providers. Using objective clinical quality and cost data, we identify providers delivering high-quality care and effective treatment planning and apply a special designation that allows them to follow modified UM protocols for their WellCare patients. This model empowers providers to self-manage while ensuring quality of care for our members, driving efficiencies in our UM program, and providing for a more focused review of providers not meeting quality and utilization goals.
- **WellCare's Provider Portal:** Our web-based, user-friendly Provider Portal enables access to data, information and systems thereby reducing the administrative burden on providers and their office staff. Providers can access our interactive Authorization Look-Up Tool, submit authorization requests online, access clinical practice and clinical coverage guidelines, view provider-specific utilization reports and access relevant administration forms, among other functions.
- **Health*Connections*:** Our award-winning, proprietary model, Health*Connections*, aims to improve the

health and vitality of our members and communities by supporting the social safety net of community resources that help our members solve for social determinants of health. The model identifies available social safety net providers across the state (such as housing assistance or food banks), assesses existing and potential gaps in the social safety net network, targets supports – financial and technical – based on measured needs identified by and in partnership with local communities, makes those resources available to members and tracks outcomes of those services. The model includes a catalogue of community-based programs and services plus mechanisms to connect members to these resources along with community planning councils and a granting program.

Accountability for Developing, Implementing and Monitoring Compliance with Utilization Policies and Procedures, and Consistent Application of Criteria by Individual Clinical Reviewers

Accountability for ensuring appropriate and consistent application of criteria begins upon employment. Upon hire, all clinical services staff responsible for medical necessity reviews complete a two week orientation followed by four weeks of classroom-based, instructor-led training. Orientation and training includes an overview of the Medicaid program, social determinants of health, an organization and department overview, education on department terminology, training on application of the varying clinical guidelines described above, benefit coverage, modules on care management resources and processes, grievance and administrative review training, HEDIS® care gap education, and all of the WellCare management information systems they will leverage, including the MMP as well as the authorization process, both expedited and standard. We include InterQual Training Modules in our training curriculum. All materials associated with this module are certified for InterQual training and the training is facilitated by InterQual Certified Instructors, of which we have nine in-house. Following the six week orientation and training, associates undergo preceptor training for up to 80 days depending on their previous work experience, performance in training, and demonstrated proficiency. Ongoing education is provided regularly to maintain and improve skills and competency in performing job functions.

Following training, newly hired UM associates are subject to routine compliance assessments to ensure appropriate review completion, including timeliness, case notes, evaluation criteria, and notifications. Additionally, we perform ongoing audits of clinical documentation and review decisions of all UM staff throughout the year to ensure accurate and consistent application of clinical criteria. As training and education are ongoing processes, WellCare provides its clinical reviewers with scheduled case studies to review and complete throughout the year. These case reviews reinforce our commitment to inter-rater reliability to proactively track and monitor decision making that is both consistent and evidence-based.

Our commitment to ensuring consistent application of criteria is further demonstrated through our independent Clinical Service Compliance (CSC) unit within Quality Management. The CSC monitors UM staff performance in meeting contractual requirements and member needs in medical necessity reviews. Each month the CSC team of licensed, clinical staff (i.e., registered nurses, licensed practical nurses, licensed clinical social workers) review a random sample of medical and behavioral health UM files for contractual standards such as turnaround times, member and provider notifications, and notification letter content. The reviewer assesses member experience and outcomes by evaluating important elements of needs assessment, discharge planning, member engagement, care coordination, and follow up for goal achievement. UM teams who are responsible for identifying opportunities for improvement and taking action receive summary reports, including staff training and coaching.

WellCare also conducts online inter-rater reliability (IRR) testing, using a commercially-available IRR product, for all clinical review staff involved in utilization decisions. The staff completes the interactive assessment through a variety of case scenarios for their respective areas of focus (i.e., behavioral health, durable medical equipment) and must assess if the services are to be approved or denied. All tested must achieve at least 85 percent on their IRR assessment. Those scoring less than 85percent undergo training, coaching, and additional oversight until they achieve desired performance expectations. Continued poor

performance results in additional disciplinary action including termination of employment. ***In 2014, our utilization management staff achieved an average score of 94.6 percent on their annual IRR testing. Our medical directors had an average score of 96 percent for the same time frame.***

Detecting and Documenting Over- and Under-Utilization of Medical Services

Using our rigorous retrospective review process we systematically and objectively examine trends, issues, and problems in utilization across physical health, behavioral health, and pharmacy services with the goal of improving health outcomes, increasing access to comprehensive health services, enhancing quality of care and reducing the rate of costly and avoidable care. The following represent key activities designed to identify and address potential over- and under-utilization of medical services.

- **Examining Utilization Management and Cost-of-Care Trends:** Each month, our Medical Economics team produces and analyzes a variety of utilization reports that use authorization, claim and encounter data to systematically identify and address emerging trends or changes in utilization patterns. The reports include, but are not limited to, admits per thousand by type (medical/surgical, deliveries, NICU, psychiatric), days per thousand by type, C-section rate, NICU average length of stay, catastrophic rate, readmit rate, and emergency department usage by provider, member, hospital and diagnosis. Our State Medical Directors, or their designee, contact outlier providers to address the specific issues identified and review clinical guidelines. The utilization data is reported to the Utilization Management Committee (UMC) where they discuss trends and potential interventions.
- **Examining Pharmacy Utilization and Quality of Care Trends:** Our retrospective drug utilization reviews (rDURs) are executed with routine examination of claims data and other records, through computerized drug claims processing and information retrieval systems to assess the clinical quality of prescribing and dispensing of our formulary medications. Our rDURs identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and members associated with specific drugs or groups of drugs. For example, our Pharmacy team identified a pattern of under-utilization of chronic inhaled corticosteroid (ICS) inhalers among members using short-acting beta agonist (SABA) inhalers. The team implemented provider-directed interventions aimed at improving the use of ICS inhalers consistent with clinical guidelines. ***Post-intervention, more than 8 percent of members identified in the initial measurement had a claim for an ICS inhaler, suggesting the intervention was effective in improving prescribing patterns.***
- **Pharmacy Network Improvement and Pharmacy Toolbox Reports Detect Inappropriate Use of Services:** Our proprietary Pharmacy Network Improvement Program reports identify potential over and under-utilization opportunities so that we can reinforce clinical guidelines and cost-effective therapeutic options. Similarly, on a monthly basis our Pharmacy team uses these reports to monitor and measure prescribing patterns and usage for a variety of pharmacy-related measures. The reports display utilization, drug evaluation review, and physician data by state.
- **Examining Trends with Adherence to Guidelines:** We regularly evaluate utilization of recommended preventive services, chronic disease management services, and acute care. We systematically mine membership data to identify trends in adherence to recommendations. Provider performance reporting and provider profiling is also reported via the Provider Portal.
- **Focused Medical Record Review Audits:** Annually our Quality Improvement department conducts medical record reviews on a random sample of charts from primary care providers. This audit assesses physician compliance with recommendations from preventive health and clinical practice guidelines. We also assess and trend provider compliance with guidelines through annual administrative data and medical record reviews for HEDIS. Areas of under- and over-utilization with related quality issues are referred to the Medical Director for the peer review process.

WellCare's Processes and Resources to Develop and Review Utilization Review Criteria

By applying actionable, evidence-based review criteria, we enable better health outcomes and optimize

UM decisions, support appropriate care, manage medical costs and foster appropriate use of resources. Our collection of criteria includes

- InterQual® Guidelines
- Behavioral Health Guidelines
- Pharmacy Guidelines
- eviCore® Guidelines
- Apollo Guidelines
- Hayes Health Technology
- Medicare Coverage Determinations
- Preventive Health Guidelines
- Clinical Coverage Guidelines

We maintain a formal process for developing and reviewing criteria that includes a systematic needs assessment, development and adoption, implementation and dissemination, as well as monitoring. WellCare's Medical Policy (MPC) and Pharmacy and Therapeutics (P&T) Committees are responsible for developing, implementing, and maintaining review criteria. MPC and P&T routinely analyze a variety of data sources including UM data (authorizations, denials, new technologies and medications, and new drug indications) to identify the need for criteria. They also use feedback and requests from our staff and contracted physicians, providers, and pharmacists as a method of identifying a need for criteria.

Once a need is identified, MPC and P&T each evaluate available criteria. If available and appropriate, our preferred approach is to adopt nationally-recognized criteria as this prevents providers from receiving conflicting information. If criteria do not exist or are insufficient, MPC or P&T commission the development of criteria or review guidelines.

Review criteria and guidelines are subject to intense review by our staff and by the respective MPC or P&T Committee. Once approved, the guidelines are submitted to our local UMC for review and approval. UMC is a multidisciplinary committee comprised of network providers.

WellCare's UM Committee: Supporting our UM Activities

WellCare's UMC is a subcommittee of the Quality Assurance and Performance Improvement Committee (QAPIC) and is responsible for promoting the delivery of quality clinical services for our members and assuring efficient and appropriate utilization of health care services. Our UMC, chaired by our local Medical Director, is responsible for the day-to-day operation and organization of the UM function including standards or practice, practice guidelines, prior authorization rules, review criteria (including the consistent application of), health care trends, and cost of care. Our UMC is a vital avenue through which network providers offer recommendations regarding our UM processes and performance improvement. **Figure 1** below describes UMC composition and functions.

Figure 1

UTILIZATION MANAGEMENT COMMITTEE		
▸ Medical Director (Chairperson) ▸ Network Physicians (Family Practice, OBGYN, Pediatrics) ▸ Provider Relations ▸ Utilization Management	▸ Specialty Provider (General Surgery, Cardiology, Pulmonology, Psychiatry, Endocrinology, Orthopedics, Neonatology) ▸ Member Services ▸ Pharmacy Services	▸ Provider Services ▸ Care Management ▸ Quality Improvement ▸ Claims ▸ Administrative Assistant
Activities and Functions		
▸ Annually reviews and evaluates the performance of the UM program ▸ Facilitates communication with network providers regarding the UM program and UM issues ▸ Provides oversight of grievances and the Appeals Committee and its processes ▸ Annually reviews and approves implementation of objective review criteria and guidelines ▸ Annually reviews and approves of the UM work plan and submission of same to the QAPIC ▸ Monitors provider requests for services authorizations ▸ Monitors medical appropriateness and medical necessity of services provided to members ▸ Reviews effectiveness of UM review process; makes changes to process as needed ▸ Ensures UM policies and procedures conform to industry standards		

SECTION IV.N UTILIZATION MANAGEMENT

81. Describe the process the MCO will have in place to determine appropriate practice guidelines (including for behavioral health), notify providers of new practice guidelines, and monitor implementation of those guidelines. *(Page limit 2 pages)*

WELLCARE'S GUIDELINES DRIVE CONSISTENCY IN CLINICAL DECISION-MAKING, IMPROVED HEALTH OUTCOMES, AND REDUCED BURDEN OF DISEASE

WellCare's practice guidelines eliminate uncertainty about practice standards by identifying and documenting diagnostic, treatment, and preventive services that work best for members in various circumstances. Our guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals, providing for uniform, population health recommendations, while considering the needs of our members, including children with serious emotional disorders and adults with serious and persistent mental illness. Our collection of practice guidelines are developed in accordance with 42 CFR 438.236(b)-(d) and includes:

WellCare's Extensive Library of Practice Guidelines

WellCare has implemented more than 540 practice guidelines for behavioral health, physical health, and pharmacy services.

- **14 behavioral health guidelines** for conditions ranging from Attention Deficit and Hyperactivity Disorder (ADHD) to Bipolar Disorder to Schizophrenia
- **29 physical health guidelines** for conditions ranging from asthma to sickle cell disease
- **More than 300 pharmacy guidelines**
- **More than 200 clinical coverage guidelines** for medical necessity of procedures and technologies

Our guidelines are a cornerstone of our physical, behavioral, and pharmacy clinical service operations informing and influencing our utilization and care management activities, member and provider education, and service coverage among others. Given their importance, we maintain a formal process for determining the need for practice guidelines, notifying providers of the guidelines, and monitoring implementation. Our framework includes a systematic needs assessment, development and adoption, implementation and dissemination, and monitoring.

Our Systematic Process to Determine the Need for Clinical Guidelines

WellCare's Medical Policy (MPC) and Pharmacy and Therapeutics (P&T) Committees are responsible for identifying the need for behavioral and physical guidelines and pharmacy guidelines, respectively, as well as for developing, implementing and maintaining these guidelines. MPC and P&T routinely analyze utilization management data including authorizations, denials, and readmissions and clinical outcomes data to identify the need for guidelines. In addition to the data analysis, the Committees monitor new technologies, new drugs, new drug indications, and new treatment modalities to identify the need for guidelines. Lastly, MPC and P&T also use feedback and requests from our staff and our contracted physicians, health care providers, and pharmacists as a method of identifying a need for guidelines.

Our Approach to Developing and Implementing Valid, Reliable Clinical Guidelines

Once a need is identified, MPC and P&T, respectively, evaluate available guidelines and criteria in consultation with participating health care professionals. If available and appropriate, our preferred approach is to adopt nationally-recognized guidelines as this prevents providers from receiving conflicting information. If, however, guidelines do not exist or are insufficient, MPC or P&T develop internal guidelines and decision tools. In our affiliate Medicaid plans, we have had success collaborating with other managed care organizations and the State Medicaid agencies in the development of guidelines.

Once guidelines are drafted, we subject them to extensive review, first, internally by our specialized staff and then through our MPC and P&T Committees. Once approved, the guidelines are submitted to our local Utilization Management Committee (UMC) for review and approval. Through UMC, providers actively participate in the review and approval of our guidelines and criteria. In addition, WellCare commits to submitting guidelines to our Nebraska Clinical Advisory Committee. Like the UMC, P&T is comprised of independent practicing physicians and pharmacists. Once approved and implemented, existing guidelines are regularly reviewed in accordance with the specific guideline policies and review schedule, or as frequently as necessary given changes from professional societies and oversight bodies.

Our Multi-faceted Approach to Inform and Educate Providers of Clinical Guidelines

Implementation of new guidelines must include the use of multiple strategies of education and outreach, and providers must be given technical assistance and resources to successfully implement the guidelines. The tactics we use include distributing guidelines through our provider portal and reinforcing with affected providers through authorization decisions and patient-centered care plans. Other tactics include integration of guidelines into our clinical systems and processes, staff training, provider orientations where we review available guidelines and online resources, changing utilization management protocols (i.e., prior authorization, limits on service, step therapy), changes in reimbursement, provider incentives, and concurrent feedback through clinical staff and Medical Directors.

Monitoring Implementation of Guidelines to Drive Transformation of Clinical Practice

WellCare has significant experience monitoring provider practice patterns to ensure providers adhere to practice guideline recommendations. Annually, our Quality Improvement department conducts medical record audits on a random sample of charts from primary care providers to assess provider adherence with practice guidelines. Additionally, we assess provider adherence with guidelines through annual administrative data and medical record reviews for HEDIS. Results of these audits, along with the resulting corrective action plans are reported through the Quality Assurance and Performance Improvement Committee and UMC.

WellCare's Pharmacy Toolbox Reports and Pharmacy Network Improvement Program (NIP) reports are also used to monitor implementation of guidelines. Our Toolbox Reports identify negative trends among prescribers across 12 clinical categories including Hepatitis C, ADHD, and others, and identify specific prescribers for education and training. These reports are used by our local Medical and Pharmacy Directors during one-on-one meetings with prescribers and are distributed through our Provider Portal. Our NIP Reports are designed to identify prescribers based on pharmacy utilization and cost trends as well as quality care gaps related to medication prescribing and adherence. Our local Pharmacy Directors use these prescribing reports to modify prescribing behaviors by promoting quality evidence-based drug therapy and best practices through face-to-face as well as telephonic communication with our providers.

DRIVING IMPROVED CLINICAL PRACTICE

A Success Story from WellCare's Georgia Affiliate

In Georgia, we identified significant opportunities to improve follow-up care for children prescribed ADHD medication for both the initiation and continuation phases. By implementing formal guidelines and conducting ongoing, targeted provider and member outreach, we have consistently increased the percentage of members who had one follow-up visit with the prescribing authority during the 30-day initiation phase from 39.39 percent in 2013 to 48.92 percent in 2015. Similarly, we increased the percentage of members of the same age group who, 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 from 53.10 percent in 2013 to 63.78 percent in 2015. Our affiliate plan in Kentucky produced similar improvements during the same timeframe. Our Kentucky plan increased the percent of members with an initial visit from 50 percent in 2013 to 61.49 percent in 2015 as well as the percent with the follow up visits from 20 percent in 2013 to 69.62 percent in 2015.

SECTION IV.N UTILIZATION MANAGEMENT

82. As one of the largest payers in Nebraska, MLTC has an important role to play to move the health care system to a more cost-effective model that improves outcomes. Provide specific initiatives the MCO will pursue to deal with "waste" in the existing system and improve outcomes. Provide specific information regarding the initiatives that will be pursued to improve quality and enhance cost containment (including the stakeholders involved, the timelines, and the desired outcomes). *(Page limit 4 pages)*

UNMATCHED EXPERIENCE IMPROVING HEALTH OUTCOMES AND COST IN MEDICAID

Today, we serve 2.4 million Medicaid members in nine states across 53 Medicaid, LTSS, and related products for eligibility groups including home and community-based services waiver, Foster Care, Children's Health Insurance Programs, Temporary Assistance to Needy Families, supplemental security income, and long-term services and supports. As an organization dedicated solely to improving the health and lives of members enrolled in government programs with a focus on low income and underserved participants, our technical expertise in product development, administrative processing, utilization management (UM), care management, and information technology systems is strong and focused precisely on optimizing health outcomes and eliminating waste. We are confident there is no managed care organization better positioned to help the State move the health care system to a more cost-effective model that improves outcomes than WellCare of Nebraska.

Figure 2

EXAMPLES OF INITIATIVES TO ELIMINATE WASTE
Preventing Inappropriate Use of Services
➢ **Emergency Department Diversion Program**
➢ **24-Hour Behavioral Crisis Hotline**
➢ **Pharmacy Network Improvement Program & Toolbox**
➢ **Medication Therapy Management Program**
➢ **Suboxone Utilization Review**
➢ Medical Cost Reviews
➢ Hospital Observation Stays
➢ Pharmacy Lock-In
➢ Focused Homeless Initiative
➢ Cobalt Therapeutics
➢ Healthy Rewards
➢ Prenatal Care Management
➢ Diabetes Telemonitoring
➢ Special Investigations Unit (SIU)
Eliminating Waste Related to Administrative Processes
➢ **Gold Card Program**
➢ Provider Portal
➢ Member Portal
➢ MyWellCare Mobile App
Preventing Waste Due to Mistakes and Defects
➢ **Pharmacy Prior Authorization Technology**
➢ Medication Reconciliation Pre-Hospital Discharge

PROPOSED INITIATIVES TO IMPROVE QUALITY AND ENHANCE COST CONTAINMENT FOR NEBRASKA

Healthcare "waste" can be widespread and varied ranging from inappropriate use of services – both over- and under-utilization – to delays, duplication of services, over-processing, mistakes and defects, and others. Our comprehensive UM program including our UM structure, prior authorization protocols, concurrent review and discharge planning processes, retrospective reviews, clinical guidelines and review criteria, and technology and automation are all designed to eliminate "waste" in the health care delivery system. As demonstrated in **Figure 2**, we have an extensive set of programs and initiatives to eliminate waste that we propose to implement upon contract award. Those in bold are further showcased below.

Preventing Inappropriate Use of Services

The issue of inappropriate use of health care services is complex, requiring a multi-disciplinary and multi-pronged approach. Upon contract award, we will implement a variety of initiatives that seek to substantially improve members' use of services improving health and well-being while optimizing health

care costs. A sample of these initiatives follows (**Figure 3**).

Figure 3

EMERGENCY DEPARTMENT DIVERSION PROGRAM	
Description	Our emergency department (ED) diversion program reduces ED expenditures by allowing us to identify and intervene with members who unnecessarily or frequently and inappropriately use ED services. Using sophisticated data analytics, we identify members in need of support. We then engage them in our Care Management program, where we conduct a comprehensive assessment to determine underlying issues and contributing factors. Based on the results of the individual assessment, we connect members to the most appropriate, cost-effective services and resources for their needs. Throughout, we communicate with the member regularly, encouraging PCP visits and relationships and provide follow-up and re-education as necessary.
Stakeholders Involved	Members, providers, WellCare's Care Management team.
Timelines	Our emergency department (ED) diversion program will be operational upon the effective date of the contract. Process related results will be available monthly while outcomes results will be available at the end of the first year and annually thereafter.
Desired Outcomes	Our desired outcomes are to reduce the incidence of inappropriate use of ED services.
24-HOUR BEHAVIORAL CRISIS HOTLINE	
Description	WellCare provides members with a 24-hour behavioral health crisis line. Should a member contact the 24/7 Behavioral Health Crisis Line, the call will be answered by a specially-trained, non-clinician, within established time frames for call handling. For true crisis calls, a behavioral health clinician immediately joins the call to assess, support and manage the situation for the most timely and effective outcome for the member. Crisis calls are triaged, and the appropriate intervention arranged based on the member's needs. The crisis call encounter is documented in our Medical Management Platform so that we may conduct follow up and further engage the member in programs and services, including care management, if appropriate.
Stakeholders Involved	Members, members' families and/or caregivers, WellCare, WellCare's subcontractor .
Timelines	This program will be operational upon the effective date of the contract. Utilization data will be available monthly while outcomes results will be available at the end of the first year and annually thereafter.
Desired Outcomes	Our desired outcomes are to provide members and caregivers with access to immediate support in the event of a crisis and reduce the incidence of ED use for crisis situations.
PHARMACY NETWORK IMPROVEMENT PROGRAM & TOOLBOX	
Description	Our Pharmacy Network Improvement Program and Pharmacy Toolbox will identify potential over and under-utilization opportunities so we can reinforce clinical guidelines and cost-effective therapeutic options. Similarly, on a monthly basis our Pharmacy team will use reports to monitor and measure prescribing patterns and usage for a variety of pharmacy-related measures.
Stakeholders Involved	Pharmacies, pharmacists, prescribers, WellCare's pharmacy team.
Timelines	This program will be operational upon the effective date of the contract. Process-related activity will be available monthly while outcomes will be reported at the end of the first year and annually, thereafter.
Desired Outcomes	Our desired outcomes are to reduce inappropriate use of medications (i.e., psychotropics), improve medication adherence, and optimize pharmacy-related costs.

MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM	
Description	Our comprehensive MTM program features: ➢ Psychotropic Medications Program ➢ Core Safety and Monitoring Program ➢ Medication Adherence Program ➢ Gaps in Care Program ➢ Polypharmacy Program ➢ ADHD Medication in Children Program
Stakeholders Involved	Members, prescribers, WellCare's Pharmacy and MTM teams.
Timelines	This program will be operational upon the effective date of the contract with monthly activity reporting available and clinical outcomes reported at the end of the first year and annually, thereafter.
Desired Outcomes	Our desired outcomes are to reduce inappropriate use of medications (i.e., psychotropics), improve medication adherence, and optimize pharmacy-related costs.
SUBOXONE UTILIZATION REVIEW	
Description	Having observed a potential for a high rate of abuse of the heroin addiction treatment product, Suboxone, we implemented Suboxone Utilization Review and implemented a formulary change to cover Zubsolv. Zubsolv has less buprenorphine than Suboxone with the same clinical indications and outcomes. Additionally, a tablet additive makes the buprenorphine in the SL tablet more highly absorbed. The presence of menthol in the tablet formulation makes the product more palatable, but less likely to be abused through injection or "snorting". Zubsolv is also less recognizable on the streets and less likely to be a target for diversion. At the same time we introduced Zubsolv to the formulary, we tightened our Drug Evaluation Review (DER) criteria to include requirements for tapering and shortened the length of the DER if the tapering was not being documented. Through these efforts we successfully reduced the average pharmacy claims per day for Suboxone by 40 percent in one year with savings equal to over $1,600,000 annually. By implementing this policy in Nebraska, we will improve medication adherence and deliver better clinical efficacy for substance use disorder as we have done in our affiliate Medicaid plans.
Stakeholders Involved	Members with substance use disorder being treated with Suboxone, prescribers, pharmacies, WellCare's Pharmacy team
Timelines	This initiative will be operational upon the effective date of the contract with monthly activity reporting available and clinical outcomes reported at the end of the first year and annually, thereafter.
Desired Outcomes	Optimize the use of Suboxone-alternative for treatment of substance use disorder

Eliminating Waste Related to Administrative Processes

Waste can occur within well-intended administrative processes through non-value added work and over-processing. WellCare routinely evaluates administrative processes to reduce or eliminate non-value added activities reducing administrative costs and improving quality. An example of a program designed to eliminate waste due to administrative processes is our Gold Card Program. Program details follow (**Figure 4**):

Figure 4

GOLD CARD PROGRAM	
Description	Our Gold Card Program, a shared-UM decision support program, will use objective clinical quality and cost data to identify facilities consistently delivering high-quality and cost-effective care and effective treatment planning. These facilities will then receive a special designation which will allow them to follow modified UM protocols for their WellCare patients. Specifically, facilities will obtain approval for inpatient admissions but will not be required to request concurrent review for medical necessity. The facility is expected, however, to inform us of discharge plans as well as interact on care coordination, care management activities, or other such activities. No days will be denied for lack of medical necessity once the admission is authorized.
Stakeholders Involved	Adult inpatient mental health facilities and WellCare's UM staff
Timelines	The program will begin nine months after the contract effective date so as to accrue six months of data (allowing for a 3-month claims lag) to analyze patient volume, quality, and average length of stay. The program will continue with quarterly evaluations.
Desired Outcomes	Our desired outcomes are to drive efficiencies in our UM program by eliminating "over-processing," deploy critical personnel resources in a highly-focused manner, to facilities not meeting quality and utilization goals, and enhance facility's experience with WellCare and foster a truly collaborative relationship by offering a greater degree of autonomy in UM decision-making.

Preventing Waste due to Mistakes and Defects

Many of WellCare's systems and processes are designed to reduce the risk of human error, detect issues before they occur, and make the health care environment more efficient. Our systems and processes reduce the risk of harm to our members, drive efficiencies and consistency, and, ultimately improve the experience for our members and providers. An example of systems and processes we will deploy to eliminate waste due to mistakes, delays, and defects is our Drug Evaluation Review, our terminology for pharmacy-related prior authorization and workflow system (**Figure 5**).

Figure 5

PHARMACY PRIOR AUTHORIZATION TECHNOLOGY	
Description	WellCare has made significant investments in pharmacy prior authorization technology, including our proprietary, role- and task-based drug evaluation review (DER) workflow system. Our DER system features built-in self-checking and process steps to support immediate detection and prevent issues and delays. ➢ Intelligent routing ➢ Color-coded alerts ➢ Integrated Decision Rules
Stakeholders Involved	Pharmacies, pharmacists, prescribers, members filling prescriptions, and WellCare pharmacy staff.
Timelines	This technology will be operational upon the effective date of the contract.
Desired Outcomes	Our desired outcomes are to provide timely, accurate, consistent pharmacy prior authorizations.

SECTION IV.N UTILIZATION MANAGEMENT

83. Describe the MCO's proposed approach to prior authorization, including:

- The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation of need for current prior authorization requirements.
- The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization.
- The role of the Clinical Advisory Committee in developing service authorization procedures.
- The MCO's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.

(Page limit 4 pages)

WellCare's Approach to Prior Authorization

WellCare views prior authorization (PA) as an important Utilization Management (UM) tool that ensures members receive the most appropriate services to meet their unique needs, in the least restrictive settings of their choice. Our philosophy is to structure our PA program to actively engage providers with WellCare so that our members receive the best care possible. Our PA program includes prospective review of select services to be rendered to ensure they are appropriate, consistent with standards of care, and are being provided in the most appropriate setting. While PA is an important tool serving many needs, **we never require prior authorization for emergency medical or post-stabilization services or crisis stabilization services.**

WellCare and our subcontractors delegated utilization management functions have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. Furthermore, we have processes to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider, when appropriate. Our PA program features highly-skilled professionals, use of nationally-recognized, evidenced-based criteria, industry-leading technology, well-documented policies and procedures, and strong clinical oversight. **Over the past two years, we have conducted 1,875,287 prior authorization reviews. On average, these reviews have been completed in two days.**

Standard Prior Authorization Procedures for Medical and Behavioral Health Services

PA requests for medical and behavioral services may be initiated by a member, a member's appointed representative with member's written consent, or provider via phone, fax, mail or the Provider Portal. Those received via the Provider Portal are automatically routed into our Medical Management Platform (MMP) whereas those received by phone, fax, or mail are manually entered. All requests, regardless of submission method, are date and time stamped to ensure they are addressed within 14 calendar days after receiving the request or as expeditiously as the member's health requires.

Upon receipt, our intake team initiates the authorization in our MMP and routes the request, via MMP, to the designated review staff, who examine the member's clinical information provided. In addition, the staff also has available all information about the member within MMP including prior inpatient stays, pharmacy claims, case notes, and care plans.

Once the member's information has been reviewed, the staff evaluates the request against nationally-recognized, established criteria including InterQual®, Hayes, our proprietary evidence-based Clinical Coverage Guidelines, and others, to assess the medical necessity of the requested services. The criteria is applied to assess the appropriateness of the request and to provide authorization. If determined to be

medically necessary and appropriate, the reviewer completes documentation in MMP and notifies the provider of the authorization by phone or fax. If the reviewer cannot approve the services requested based on the information received and applicable criteria, the request is routed, via MMP, to a Medical Director for secondary review. This ensures that decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by a practitioner with the necessary credentials and experience, and who has appropriate clinical expertise in treating the member's condition or disease. If the Medical Director approves the request, it is returned to the reviewer to complete the documentation and notification as previously described. If the Medical Director does not approve the request or it is reduced, suspended, or terminated, the reviewer completes the documentation in MMP and informs the provider verbally or by fax of the reason for the decision and offers the opportunity to discuss the adverse determination with the Medical Director. If the decision remains unfavorable, we mail the required written notice of adverse action to the member, requesting provider, and the member's primary care provider. The notice, which complies with the requirements of 42 CFR 438.404, includes the reason for the adverse action and information pertinent to the action including provider appeal rights.

Standard Prior Authorization Procedures for Pharmacy Services

As with PA requests for medical and behavioral services, pharmacy Drug Evaluation Review (DER) requests, WellCare's process for medication-related prior authorization, may be initiated by a member, a member's appointed representative with member's written consent, or a member's prescribing physician and may be submitted via fax, web, phone or mail. Those received via web or fax are automatically routed into our proprietary DER workflow system for processing, while those received by phone or mail are manually entered.

Upon receipt, an intake coordinator opens the DER documenting details of the request including member demographic data. The system utilizes the demographic data to confirm member eligibility real-time. If the drug is an injectable or narcotic medication, the coordinator identifies that which automatically routes the DER request to technicians who are skilled in processing DERs for these types of medications. This flagging also triggers the DER for pharmacist review later in the process. Once the intake coordinator completes the initial data entry, he or she submits the DER to the queue to be processed by a pharmacy technician.

DERs are automatically assigned from the central queue to each technician's queue when logged into the system and is processed based on program and drug type. To process the DER, the technician validates member eligibility for prescription coverage. They then confirm that the requested drug is in Medispan and properly listed with the FDA. The system then automatically checks its archives for possible duplicate requests (i.e., same member, drug name, and drug strength) received within the previous 30 days. If a duplicate is found, the technician follows protocols for duplicate DERs. If no duplicates are found, they process the request. An initial evaluation is made to approve or deny based on the information in the DER and in the member's prescription profile using pharmacy operations tools (i.e., state-specific Provider manuals, national clinical guidelines, excluded medication lists). If the decision is to approve, the technician enters information into the pharmacy benefit manager's (PBM) claim system to allow the claim to adjudicate properly. If the decision is to deny, they document the diagnoses written on the DER, the quantity requested, the appropriate denial reason code, and any other relevant information and documentation. If approved and the medication does not require pharmacist review, the system generates a Drug Utilization Review (DUR) form containing the approval date range and reason and automatically faxes the form to the prescriber and pharmacy, if the pharmacy has requested notification. If, however, the request has been denied or approved pending clinical pharmacist review, the request is routed to the pharmacist queue.

Upon receipt, the pharmacist reviews all information provided. If they disagree with the denial decision, the request is returned to the technician, including the rationale. The technician adjusts the request and

processes the approval. If the pharmacist agrees with the denial, and it does not require Medical Director review, the system creates a DUR form and automatically faxes it to the prescriber and the pharmacy, if notification has been requested. Otherwise, the request is routed to a Medical Director for review where he/she can uphold the denial or overturn the decision, routing it back to the technician for processing.

Determining Which Services Require Authorization: A Thoughtful Approach

In collaboration with our contracted practitioners, our Medical Policy (MPC) and Pharmacy & Therapeutics (P&T) Committees establish and maintain our PA requirements. The Committees structure our PA rules to ensure alignment to standards of care, to enable the delivery of care by providers, to support members' navigation through the health care delivery system, and to prevent the risk of over-utilization of services.

The Committees use a variety of data sources to evaluate our PA rules and determine where to add, remove, or change PA requirements. Data reviewed and analyzed include:

- State and Federal requirements
- Benefit structure
- Market fee schedules
- Requirements for emerging technologies and medication
- CPT code-level utilization and claim data
- Approval and adverse determination data
- Quality performance measures

Upon contract award, we will enhance our approach to determine which services require authorization by extending the review to our Nebraska Clinical Advisory Committee (CAC). We also acknowledge that our prior authorization procedures must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract's start date.

Services from Non-Participating Providers: Doing What is Best for Members

Requests for services from non-participating providers demand special attention. Upon receipt of a request for services where the provider is non-participating, our Utilization Management (UM) staff reviews the request to determine if there is a participating provider who may be able to care for our member. The use of participating providers is vitally important to us for member safety. As part of our credentialing process, we have verified the provider is trained, qualified, and licensed, is eligible to participate in Medicaid and Medicare, carries appropriate liability insurance, and has passed appropriate quality checks and site visits. In addition, given the depth and breadth of provider data available to us through our clinical systems, using participating providers also allows us to direct members to high-quality providers known to produce good health outcomes. Upon review, if an alternate participating provider is identified, our UM staff contacts the provider's office to confirm the provider's availability. Once confirmed, the UM staff works with the member and the provider to safely transition the member in-network issuing the authorization and providing the authorization number and the dates of service.

While this method is our preferred approach to facilitating access to care, there are circumstances where it is in the member's best interest to authorize services with a non-participating provider especially, in cases where there is limited availability of highly-specialized providers or providers who have experience caring for members with special needs. In these instances, our UM staff reviews State and Federal databases to ensure the provider is eligible to provide care. Once validated, the staff negotiates a single-case agreement with the provider.

Expediting Requests for Prior Authorizationto not Jeopardize members' Health

WellCare offers expedited reviews for prior authorizations in situations when standard review could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Providers and members may request an expedited review. In addition to provider and member requests for expedited service authorization decisions, our staff are specially trained to evaluate standard requests.

They may determine that a member's clinical circumstances necessitate expedited review and flag the request accordingly. **In 2014 and 2015 we conducted over 26,000 and 34,000 expedited reviews, respectively, completing them, on average, in one day.**

Expedited DER Requests

In 2014, WellCare's average time to process expedited DER requests was less than 20 hours.

CLINICAL ADVISORY COMMITTEE: DEVELOPING SERVICE AUTHORIZATION PROCEDURES

WellCare's vision for our Heritage Health Clinical Advisory Committee (CAC) is to convene an expert panel of Nebraska-based clinicians in the fields of physical health, behavioral health and pharmacy to provide peer review and feedback on proposed practice guidelines and our Care Management (CM) and Utilization Management (UM) policies and procedures. To that end, and in compliance with all requirements of the this RFP, our Nebraska CAC will be comprised of clinicians who are familiar with standards and practices of treatment, including diseases and chronic conditions common in the Heritage Health population and mental health and/or substance use disorder treatment for.

WELLCARE'S PROCESS FOR NOTIFYING MEMBERS AND PROVIDERS OF DENIALS

Timely UM reviews are critical for patient safety and a positive member experience. Our UM processes are designed to 1) promote timely decision-making and notifications and 2) support members and providers through adverse actions.

WellCare's Process for Notifying Providers of Denials Verbally or in Writing

Upon review, if a request for medical or behavioral services is denied, reduced, suspended or terminated, our UM staff immediately notify the requesting provider via phone or fax. The provider is given a clear description of the reason for the denial, alternative treatment options, and important information pertinent to the action, including the provider appeal rights. Similarly, if the denial is for pharmacy services, we generate the drug utilization review (DUR) form which is immediately faxed to the prescriber and the pharmacy, if the pharmacy has requested notification. The DUR includes a clear description of the reason for the denial, any preferred alternatives, and other information pertinent to the action. All communication with the provider is noted in MMP or our DER system and the notification is retained for future reference.

WellCare's Proces for Notifying Members, in Writing, of Denials or Decisions to Authorize Services in Amount, Duration, or Scope That is Less than Requested

For all notices of action relating to adverse actions, we generate a written notice of action letter as soon as the decision is made and mail it to the member, requesting provider, and the member's primary care provider. The notice is mailed within 14 calendar days of receipt of the request if it is a standard review or within 72-hours for expedited requests. As with provider notifications above, the written notices are documented and retained within our MMP or DER system. In all cases, the notice explains

- The action WellCare has taken or proposes to take as well as the reason for the action
- The guidelines used as a basis for the decision and information about how to obtain a copy
- The right to appeal the decision and instructions for doing so including member's requirement to exhaust internal appeals before engaging in a State fair hearing
- Instructions for how to expedite the review as well as information about how to continue the benefit while under review and the potential obligation to pay under certain circumstances

SECTION IV.N UTILIZATION MANAGEMENT

84. Provide a listing of services for which the MCO will require prior authorization and describe how the MCO will communicate this information, as well as the results of authorization decisions, to providers and members. *(Page limit 2 pages excluding the listing of services)*

PROPOSED LIST OF SERVICES FOR WHICH PRIOR AUTHORIZATION WILL BE REQUIRED

Prior authorization is an effective method for ensuring the efficient use of covered services. Our prior authorization procedures comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). Per our policy, **we do not require prior authorization for emergency medical and post-stabilization services or for crisis stabilization services.** The proposed list of services for which prior authorization will be required is available in the attached list (**Attachment 84a_Proposed List of Services for which Prior Authorization will be Required**).

COMMUNICATING PRIOR AUTHORIZATION REQUIREMENTS TO MEMBERS AND PROVIDERS

WellCare transparently communicates prior authorization requirements to members and providers through a varierty of print, digital media, telephone, face-to-face, and written channels.

Communicating Prior Authorization Requirements to Members

WellCare uses a variety of channels to communicate with members about the services available to them and which require prior authorization including:

- **Member Handbook:** Our member handbook provides comprehensive information about covered services. It features easy-to-read descriptions of prior authorization requirements.
- **Member Portal:** Our portal provides members with access to critical information 24-hours a day, everyday, including valuable information about covered services, which require authorization, timeframes for review, who can request authorization, and important phone numbers.
- **Member Services:** We encourage members to call for questions related to their health care coverage, including which services require prior authorization. Our trained associates provide detailed information and can instruct members on where to locate the information in their materials.
- **Welcome Centers:** Our Welcome Centers in Lincoln, Omaha, Kearney, Scottsbluff, and Norfolk will be staffed by a team of specialists who will provide local access to service and support. They will assist members in understanding covered services, including which ones require authorization.

Communincating Prior Authorization Requirements to Providers

We provide our providers with access to a variety of easy-to-use reference materials, tools, and communications as it pertains to prior authorization rules. These include:

- **Provider Manual:** Our Provider Manual Provides information about prior authorization including instructions for how to obtain authorization for services.
- **Provider Quick Reference Guide (QRG):** The QRG features detailed information about covered procedures and services, if authorization is required, how to request authorization, and any special processing instructions. In addition, the QRG, includes detail about the information needed to obtain authorizations including a place of service code reference tool.
- **Provider Portal:** Offers providers the convenience of exchanging health care service information directly with WellCare. The provider portal, which is offered at no cost, features a wealth of information and tools including our proprietary authorization look up tool. Additionally, providers can seamlessly transistion to requesting authorizations and check status
- **Web-based Provider Authorization Look Up Tool:** Our proprietary web-based authorization look

up tool allows providers to quickly check if prior authorization is required and, if so, under what conditions. By simply entering a valid CPT-code, our embedded business logic checks prior authorization rules and renders information about about the service including a description and requirements by place of service.

- **Provider Services, Pharmacy Support, and UM Staff:** Our associates are well-trained in assisting providers in understanding what services require authorization and how to obtain approval.
- **Specific provider notices when prior authorization rules change:** When prior authorization rules are modified, WellCare sends providers advance notification of the changes.
- **Provider Orientations:** WellCare's New Provider Orientation Training includes a comprehensive overview of our UM program including prior authorization procedures and rerquirements.

Communicating Results of Authorization Decisions to Providers and Members

Our UM processes are designed to provide timely communication to providers and members.

Communicating Results of Authorization Decisions to Providers

All requests for medical and behavioral health services submitted to Wellcare are date and time stamped when received. The reviewer completes the determination as expeditiously as the member's health requires, but no later than 14 calendar days after receiving the request. If the final determination is approval the reviewer notifies the requesting provider of the approval via telephone or facsimile. If the determination is unfavorable, the request is routed to a Medical Director for review. If the Medical Director's final determination is unfavorable (i.e., denied, reduced, suspended, or terminated), the reviewer immediately notifies the requesting provider of the denial via telephone or facsimile. The provider notification includes a clear explanation of the reason for the denial, any preferred alternative treatments, and important information pertinent to the action including provider appeal rights. The fax notification includes the UM department's contact information to allow providers the opportunity to discuss the adverse determination. For all adverse determinations, the provider also receive a copy of the written notice of action letter.

Upon receipt of a request for drug evaluation review (DER) we systematically date and time stamp the request. This information is used to engage our DER system's alert feature. All pending requests are systematically color-coded based on approaching deadlines. Upon review, if the request is approved, we generate a fax which is sent immediately to the prescriber and the pharmacy. If the request is denied, we generate a drug utilization review (DUR) form which is immediately faxed to the prescriber and the pharmacy, if the pharmacy requested to be notified. The DUR includes a clear description of the reason for the denial, any preferred alternatives, and other information pertinent to the action.

Communicating Results of Authorization Decisions to Members

As services are approved, we notify providers in a timely manner so they can proceed with notifying and caring for the member. For all adverse actions, we generate a written notice of action letter as soon as the decision is made and mail it to the member or member's representative and provider(s). The notice is mailed within 14 calendar days of receiving the request if it is a standard review or within 72-hours for expedited requests. In all cases, the notice explains:

- The action WellCare has taken or proposes to take along with the reason for the action
- The guidelines used as a basis for the decision and information about obtaining a copy
- The right to appeal or grieve the decision and instructions for doing so including the member's requirement to exhaust internal appeals before engaging in a State fair hearing
- Instructions on expediting the review as well as information about how to continue the benefit while under review and the potential obligation to pay under certain circumstances

PROPOSED LIST OF SERVICES FOR WHICH PRIOR AUTHORIZATION WILL BE REQUIRED	
WellCare of Nebraska	
Physical Health Services	**Prior Authorization Required**
Emergency Medical and Post-Stabilization Services	No
Inpatient hospital services, including transitional hospital services and transplant services	Yes
Outpatient hospital services	Select
Ambulatory surgical center (ASC) services	Select
Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist	No
Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs)	No
Services provided in Indian Health Service (IHS) facilities	No
Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis	Select
Radiology services	Select
Health Check (EPSDT) services	No
Home health services	Yes
Private duty nursing services	Yes
Therapy services (Physical & Occupational therapy, Speech pathology & audiology)	Yes
Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements	Select
Podiatry services	Select
Chiropractic services	No
Vision services	No
Free standing birth center services	Select
Hospice services, except when provided in a nursing facility	No
Skilled/rehabilitative and transitional nursing facility services	Yes
Emergency ambulance services	No
Non-emergency ambulance transportation	Yes
Transplant services	Yes
Pharmacy services	Select
Family planning services	No
Dialysis services	No
Prenatal and Maternity Care Services	Select
Hysterectomies and Sterilizations	Select
Medical Services for Special Populations	Select

PROPOSED LIST OF SERVICES FOR WHICH PRIOR AUTHORIZATION WILL BE REQUIRED	
WellCare of Nebraska	
Behavioral Health Services	**Prior Authorization Required**
Services for individuals age 20 and under, unless otherwise indicated Crisis stabilization services (includes treatment crisis intervention)	No
Inpatient psychiatric hospital (acute and sub-acute)	Yes
Psychiatric residential treatment facility (age 19 and under)	Yes
Outpatient assessment and treatment: - Partial hospitalization - Day treatment - Intensive outpatient - Medication management - Outpatient therapy (individual, family, or group) - Injectable psychotropic medications - Substance use disorder treatment - Psychological evaluation and testing - Initial diagnostic interviews - Sex offender risk assessment - Community treatment aide (CTA) services - Comprehensive child and adolescent assessment (CCAA) - CCAA addendum - Hospital observation room services (up to 23 hours & 59 minutes in duration) - Parent child interaction therapy - Child-parent psychotherapy - Applied behavioral analysis - Multi-systemic therapy - Functional family therapy	Select
Rehabilitation services - Day treatment/intensive outpatient - CTA services - Professional resource family care - Therapeutic group home	Yes
Services for adults age 21 and over Crisis stabilization services (includes treatment crisis intervention)	No
Inpatient psychiatric hospital services (acute and sub-acute)	Yes
Outpatient assessment and treatment: - Partial hospitalization - Social detoxification - Day treatment	Select

PROPOSED LIST OF SERVICES FOR WHICH PRIOR AUTHORIZATION WILL BE REQUIRED	
WellCare of Nebraska	
Behavioral Health Services	**Prior Authorization Required**
– Intensive outpatient – Medication management – Outpatient therapy (individual, family, or group) – Injectable psychotropic medications – Substance use disorder treatment – Psychological evaluation and testing – Electroconvulsive therapy – Initial diagnostic interviews – Ambulatory detoxification – In-home psychiatric nursing	
Rehabilitation services – Dual-disorder residential – Intermediate residential (SUD) – Short-term residential – Halfway house – Therapeutic community (SUD only) – Community support – Psychiatric residential rehabilitation – Secure residential rehabilitation – Assertive community treatment (ACT) and Alternative (Alt) ACT – Community support – Day rehabilitation	Yes

SECTION IV.N UTILIZATION MANAGEMENT

85. Describe how the MCO will ensure members receive written and timely notice of action relating to adverse actions taken by the MCO. *(Page limit 1 page)*

WELLCARE'S PROCESS FOR ENSURING MEMBERS RECEIVE WRITTEN AND TIMELY NOTICE OF ACTION RELATING TO ADVERSE ACTIONS

Anytime we determine a request for services is to be denied, reduced, or suspended, we send a written notice of action. Notices for medical and behavioral services are generated as soon as the final decision is made, and they are mailed within 14 calendar days of receipt of the request for standard reviews or within 72-hours for expedited requests. Once a final determination that a request will be denied, reduced, suspended, or terminated, the reviewer completes the documentation in our Medical Management Platform (MMP) and prepares notices for the member, the requesting provider, and the primary care provider. Our notices comply with the requirements of 42 CFR 438.404 and include the reason for the adverse action, information pertinent to the action, and appeal rights including the right to continue benefits while under appeal. Draft notices are immediately routed, via MMP, to our Utilization Management (UM) quality team where they are to be reviewed. The quality auditor reviews each letter for completeness, accuracy, and readability giving first priority to those notices for expedited reviews. Upon completion of the review, notices are batched and transmitted to our print vendor two times a day. Upon receipt of the files, our print vendor provides us with written, electronic acknowledgment to ensure files or records are not missed.

For pharmacy, ensuring timely notice of action relating to adverse actions begins upon receipt of a request for drug evaluation review (DER). Requests are systematically date and time stamped which engages our DER system's alert feature. This feature color-codes pending requests based on approaching deadlines. DERs due to be completed within four hours are indicated in yellow, while those due within an hour are indicated in red. All pharmacy-related adverse determinations are transmitted to our print vendor through our enterprise correspondence tracking system. The print vendor provides written, electronic acknowledgement of receipt. As an added measure, our print vendor also provides confirmation that the notices have mailed by supplying the actual postmark date, which is also stored in our correspondence tracking system. This is our last measure to ensure timely notification.

Managing the Notice of Action Letters to be Sent

Our UM quality team managers routinely monitor the queues of adverse determination notices to be prepared and sent. Each morning the manager reviews the Exception Report. This report shows all requests for authorization including the date received, the date reviewed, the authorization status, and the date the notice was processed. Our manager uses this reporting to identify pending notices so they can be appropriately triaged.

Direct Communication with Providers Helps Ensure Members Receive Timely Notice

For those medical and behavioral reviews that result in an adverse action (i.e., denied, reduced, suspended, or terminated), prior to sending the written notice of action, our staff immediately notifies the requesting provider of the denial via fax and telephone, if necessary. Our staff inform the provider of the reason for the denial, offer any preferred alternatives, and information pertinent to the action including the right to a peer-to-peer discussion with a medical director and provider appeal rights. For pharmacy-related adverse actions, we generate the drug utilization review (DUR) form which is immediately faxed to the prescriber and the pharmacy, if the pharmacy has requested notification. The DUR includes a clear description of the reason for the denial, any preferred alternatives, and other information pertinent to the action. We believe our efforts to immediately notify the provider and provide written notification, hensure the best determinations and communications for our members.

SECTION IV.N UTILIZATION MANAGEMENT

86. Describe the MCO's process for conducting concurrent reviews for inpatient services. *(Page limit 2 pages)*

WELLCARE'S PROCESS FOR CONDUCTING CONCURRENT REVIEW FOR INPATIENT SERVICES

Concurrent review is an essential component of our Utilization Management (UM) program as well as an integral part of our Care Management (CM) program. Our concurrent review staff evaluates, monitors, and supports individual WellCare members when they have been admitted to any one of our nearly 1,000 contracted hospitals, psychiatric facilities, psychiatric residential treatment facilities, rehabilitation centers, and nursing facilities. **More than fifty percent of our concurrent review staff are onsite at contracted facilities providing individualized, person-centered support to our members. Our NICU and behavioral health concurrent review professionals provide even further specialized, high-touch services to especially vulnerable populations**. Our concurrent review program is aligned to the Institute for Healthcare Improvement's Triple Aim framework to improve patient care experience, improve population health, and reduce health care costs.

Improving Health, Experience, and Cost Begins Upon Admission

Quality inpatient care occurs when services are appropriate and members are appropriately supported, which is why we believe it is vitally important to initiate concurrent review upon notification of an admission. Upon notification that a member has been admitted to a facility, our intake team initiates the authorization in our Medical Management Platform (MMP) and then routes the admission, via MMP, to the designated concurrent review staff for that facility. The concurrent review professional carefully reviews the member's clinical information contacting the facility directly if additional information is missing or needed to support the review. In addition to reviewing the clinical information related to the member's current admission, the concurrent review staff also has available all information about the member within MMP including prior inpatient stays, pharmacy claims, case notes, and care plans. As our universal health record for medical, behavioral, pharmacy, and care management activity, our MMP allows our concurrent review staff to complete a comprehensive review of the member's history, needs, and circumstances which then informs our concurrent review, discharge planning, and post-discharge activities.

Evaluating Admissions for Appropriateness

Once the member's current and historical clinical information has been reviewed, the concurrent review professional evaluates the member's current inpatient stay for medical necessity to ensure that the services are medically appropriate and

- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner and 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 convenience of the client or his/her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Of demonstrated value
- No more intensive level of service than can be safely provided

Using commercially-available, nationally-recognized, internally approved criteria such as InterQual®, American Society of Addiction Medicine (ASAM) criteria, and our proprietary evidence-based Clinical Coverage Guidelines, we assess quality of care and the appropriate level of care for continued stay taking into consideration the member's individual needs. We make concurrent review decisions within one calendar day from receipt of request and have provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on medical necessity.

If the concurrent review professional determines the member's stay is medically necessary and appropriate, he/she completes documentation in MMP and notifies the facility of the authorization. Subsequent reviews are scheduled based on the severity of the member's illness, intensity of services rendered, complexity of the member's treatment plan, and discharge planning activity. If the concurrent review professional cannot approve the inpatient services requested based on the information received and applicable medical necessity criteria, the request is routed, via MMP, to a designated Medical Director for secondary review. Our Medical Directors review each case individually and render a decision based on a combination of the information provided, clinical judgement, and in consideration of the best interests of the member and his/her health care needs. If the Medical Director approves the request, it is returned to concurrent review professional to complete the documentation and notification as previously described. If the Medical Director does not approve the request, the concurrent review staff completes the documentation in MMP and informs the facility verbally or by fax. We offer the attending physician the opportunity for a peer-to-peer discussion with the Medical Director. If, based on the peer-to-peer discussion, the request is approved, we update MMP and notify the facility accordingly. If the discussion does not change the adverse determination, we inform the attending provider of his/her right to initiate an appeal and provide instructions.

Ensuring Quality Care Through the Member's Inpatient Stay and Supporting Safe, Timely Transition Through Discharge Planning

After the stay is authorized, our staff focuses on ensuring a safe transition out of the inpatient facility through effective inpatient oversight and comprehensive discharge planning. Our concurrent review staff provides highly-individualized, person-centered support to our members through a mix of onsite, telephonic, or faxed clinical review and communication with the health care professionals involved in the member's care. In Nebraska, we will use the mix of onsite, telephonic, and faxed review and communication with the 67 critical access hospitals and other facilities. In facilities where we staff onsite concurrent review professionals, our staff will be at the member's bedside for the initial screening. Our experience has demonstrated the significant value of face-to-face contact with the member or caregiver in allowing for a more comprehensive identification of and planning for discharge-related needs. The concurrent review professional oversees the member's inpatient stay and develops the discharge plan, which is provided to the member's care manager who ensures a smooth transition post-discharge. The coordination between concurrent review and care management staff provides seamless coordination of care across settings.

Discharge Planning

We take a synergistic approach to working with our facilities' discharge staff in order to provide our members' safe transition and to prevent the risk of readmission. By working collaboratively with the facilities, we reduce duplication of work in identifying and addressing the collective set of medical, behavioral, and social issues that may require post-inpatient intervention. Our member-centric discharge planning process involves the attending physician, facility discharge planner, our concurrent review professional, the member and his/her caregivers, ancillary providers, care managers, when appropriate, and community resources. In doing so, we facilitate delivery of the most appropriate services for the member and empower the member and caregivers to have a voice in health care decision-making and discharge plan development. Once drafted, discharge plans are reviewed and adjusted as needed with each subsequent clinical review.

SECTION IV.N UTILIZATION MANAGEMENT

87. Describe the MCO's process for conducting retrospective reviews to examine trends, issues, and problems in utilization. *(Page limit 2 pages)*

CONDUCTING RETROSPECTIVE REVIEWS TO EXAMINE TRENDS AND PROBLEMS IN UTILIZATION

WellCare's retrospective review process supplements our procedures to prospectively and concurrently drive appropriate use of services. Our process for conducting retrospective reviews includes systems to identify, collect, and analyze utilization patterns of all network providers, written policies and procedures, methods and resources to focus on individual and system outliers, peer review, processes to monitor and report over- and under-utilization of services at all levels of care, capabilities to evaluate trends by race, ethnicity, gender, and age, and processes for claim denials through retrospective review that ensure that claims are denied individually and denials are subjected to due process before payment is withheld or repaid. Our policies and methods are explicitly designed to improve health outcomes, increase access to comprehensive health services, enhance quality of care, and reduce the rate of costly and avoidable care.

Each month, our teams of state-based and national analytics professionals produce a comprehensive set of reports across a variety of health care utilization categories. These reports allow our teams to analyze utilization relative to historical trends, goals, benchmarks, and our affiliate Medicaid plans in other states. The data is presented at various levels including state, region (if applicable), provider group, individual provider, and member, where appropriate. Following completion of our data analysis, our relevant experts throughout the organization develop and implement interventions specific to the observed data trends and the State's unique needs and circumstances.

Examining Utilization Management and Cost of Care Trends

Our Medical Economics team routinely produces and analyzes utilization reports that use authorization, claim, and encounter data to allow us to systematically identify and address emerging trends or changes in utilization. The reports include, but are not limited to, admits per thousand by type (medical/surgical, deliveries, NICU, psychiatric), days per thousand by type, C-section rate, NICU average length of stay, catastrophic rate, readmission rate, and emergency department usage by provider, member, hospital and diagnosis.

The team compares results to established goals as well as benchmarks or targets. Data analysis includes statistical models that identify patterns of inappropriate ER use, office visit up-coding, and improper billing patterns. Our State Medical Directors contact outlier providers to address specific issues identified and review clinical guidelines, where applicable. The utilization data is reported to the Utilization Management Committee where they discuss trends and recommendations for broad action.

In addition, each month our Medical Economics department facilitates state-specific Medical Cost Review meetings where a multi-disciplinary team reviews state-specific trends related to financials, medical cost and utilization, emergency department utilization, audit recovery, contracting, utilization management, and pharmacy network improvement. The analysis includes critical insights and observations from our affiliate Medicaid plans, which often allows us to proactively identify potential trends. Once the data is analyzed the team identifies areas for improvement along with interventions. Status of follow ups and trends are monitored at subsequent meetings to ensure timely completion and effectiveness in driving change. This process is replicated annually providing a retrospective review of the full year allowing us to prepare for emerging or predicted trends and planned activities.

Examining Pharmacy Utilization and Quality of Care Trends

Our retrospective drug utilization reviews (rDURs) are executed with routine examination of claims data and other records, through computerized drug claims processing and information retrieval systems to

assess the clinical quality of prescribing and dispensing of our formulary medications. Our rDURs are designed to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and members associated with specific drugs or groups of drugs. WellCare performs rDUR projects throughout the year to improve the quality of health services provided to our members. One example is related to a pattern of under-utilization of chronic inhaled corticosteroid (ICS) inhalers among members using short-acting beta agonist (SABA) inhalers. Our pharmacy team implemented provider-directed interventions aimed at improving the use of ICS inhalers consistent with evidence-based guidelines. Post-intervention, more than 8 percent of members identified in the initial measurement had a claim for an ICS inhaler, suggesting the intervention was effective. Our proprietary Pharmacy Toolbox reports are central to our pharmacy retrospective reviews. On a monthly basis, our Pharmacy team uses our Pharmacy Toolbox to monitor and measure prescribing patterns and usage for a variety of pharmacy-related measures. Our Pharmacy Toolbox reports display utilization, drug evaluation review, and physician data by state for each month as well as year-to-date.

Examining Trends with Adherence to Guidelines

We regularly evaluate utilization of recommended preventive services, chronic disease management services, and acute care. We systematically mine membership data to identify trends in adherence to recommendations. Annually, in accordance with our medical record review policy, our Quality Improvement department conducts medical record reviews on a random sample of charts from primary care providers. Our medical record audit assesses physician compliance with recommended preventive health and clinical practice guidelines. We also assess and trend provider compliance with guidelines through annual administrative data and medical record reviews for HEDIS.

Our efforts to examine trends in adherence to guidelines have allowed us to make improvements in the care provided to our members. For example, in Georgia, we identified significant opportunities to improve follow-up care for children prescribed ADHD medication for both the initiation and continuation phases. By implementing formal guidelines, conducting ongoing, targeted provider and member outreach, and monitoring adherence, we have consistently increased the percentage of members who had one follow-up visit with the prescribing authority during the 30-day initiation phase from 39.39 percent in 2013 to 48.92 percent in 2015. Similarly, we increased the percentage of members of the same age group who, 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 from 53.10 percent in 2013 to 63.78 percent in 2015. Our affiliate plan in Kentucky produced similar improvements during the same timeframe. Our Kentucky plan increased the percent of members with an initial visit from 50 percent in 2013 to 61.49 percent in 2015 as well as the percent with the follow up visits from 20 percent in 2013 to 69.62 percent in 2015.

Examining Trends for Potential Fraud, Waste and Abuse

Our Special Investigations Unit (SIU) uses General Dynamics STARS® SOLUTIONS analytical tool to analyze medical and pharmacy claims and generate outlier and trending reports focused on peer-to-peer comparisons.

IMPROVING HOW WE EXAMINE TRENDS, ISSUES, AND PROBLEMS IN UTILIZATION

WellCare is continuously investing in our medical management platform and predictive models. With respect to our data analytics and predictive modeling, we are planning to increase the frequency by which the predictive model is run to weekly to identify higher risk members more quickly. We are also implementing the use of lifestyle data, such as Experian, to increase sensitivity and specificity of predictive model and risk stratification. In addition, we are continuously evaluating automated business rules to generate case management referrals from pre-determined procedure codes captured at the time of authorization to enable immediate identification of members potentially in need of case management as the population health needs evolve.

SECTION IV.N UTILIZATION MANAGEMENT

88. Describe the initiatives the MCO will implement to control unnecessary ED utilization, avoidable hospitalizations, and hospital readmissions.

- Discuss how the MCO will ensure that care is provided in the most appropriate and cost effective setting
- Include strategies that address access to primary care services through patient centeredness principles; the use of urgent care centers and retail clinics; and interventions targeted to super-utilizers, such as patients with asthma, diabetes, chronic pain, and/or behavioral health conditions

(Page limit 6 pages)

ENSURING APPROPRIATE USE OF SERVICES WHILE ADDRESSING UNMET HEALTH NEEDS

WellCare has developed utilization management (UM) policies and processes to prospectively and concurrently evaluate utilization to ensure care is provided in the most appropriate and cost-effective setting. Our comprehensive surveillance systems allow us to quickly identify when there may be inappropriate use or over-use which may be attributed to broader issues related to access or underlying health or psychosocial issues. Through early identification and intervention, we control unnecessary emergency department (ED) use, hospitalizations, and readmissions. Our overall approach ensures care is appropriate and in the most cost-effective setting and provides the enhanced benefit of improving care and lowering healthcare-related costs. Our approach features:

- Targeted initiatives and value-added benefits and services to control unnecessary ED utilization, avoidable hospitalizations and readmissions
- Policies and processes that ensure care is provided in the most appropriate and cost-effective setting
- Strategies that address access to primary care services through patient-centeredness principles
- Strategies that address the use of urgent care centers and retail clinics
- Quality and care management strategies (including field-based care management) to address super-utilizers, particularly those with chronic and co-morbid conditions

CONTROLLING UNNECESSARY ED UTILIZATION, AVOIDABLE HOSPITALIZATIONS, AND READMITS

We offer a number of targeted interventions to improve members' continuity of care, health outcomes, and quality of life while improving use of services and related costs. Some of these initiatives include, but are not limited to:

- 24-Hour Nurse Advice Line
- Providers Who Offer Extended Office Hours
- Care gap monitoring and reporting, including mapping of care gaps to identify geographic trends in care gaps
- Use of Hospital Observation Stays
- Comprehensive Discharge Planning
- Promotion of patient-centered care through the use of the Patient-Centered Medical Home (PCMH) and Integrated Health Home models

24-Hour Nurse Advice Line

Since data shows us that members sometime us the emergency department for routine care, we offer a 24-hour nurse line. Members are able to access our nurse line at any time through our dedicated toll-free member services line. Our 24-hour nurse line team uses a nationally recognized triage decision-making tool to assist the member in deciding whether to see their doctor, go to an urgent care center, or seek

immediate emergency care. Nurses who answer the nurse line are able to assist the member in making an appointment with their PCP when appropriate as well as locating the closest urgent care center. Our nurse line plays a pivotal role in our program by directing members to the most appropriate site for care and, in return, lowering the cost of care. Nurse line staff includes Spanish-speaking nurses, and interpreter services are available for other languages.

Providers Who Offer Extended Office Hours

WellCare's network development strategy includes recruiting provider offices who offer extended office hours including evenings and weekends. Additionally, our PCMH Implementation plan has incentives for providers who meet certain PCMH standards, including offering after-hours.

Figure 6

We go beyond contracting with providers who offer extended hours, working diligently to make it easy for members to find these providers. Our Member Services associates can easily assist members but we empower members and promote self-management by offering self-service as well. Our provider directories feature provider office hours and we have implemented an easy-to-use index dedicated to finding providers who offer extended hours, as demonstrated in **Figure 6**.

Use of Hospital Observation Stays

One of the initiatives we have implemented to prevent avoidable admissions is the use of hospital observation stays. Upon review of a request for an inpatient confinement, our staff carefully evaluates the member's clinical circumstances and their health care needs. If the circumstances do not meet medical necessity criteria, our staff outreach to the facility to determine if there is additional clinical information. If there is not additional information but it appears to be in the member's best interest to remain at the facility, our staff will consult with the facility to suggest the physician orders for an observation stay. Once the updated physician order is received, the request is processed for an observation stay as opposed to an inpatient admission.

Comprehensive Discharge Planning

We have designed our discharge planning process to provide early identification of all medical, behavioral, and social issues that may require post-inpatient intervention inclusive of transportation, home health, medication needs and others. Our member-centric discharge planning process involves the attending physician, facility discharge planner, our concurrent review professional, the member and his/her caregivers, ancillary providers, care managers, when appropriate, and community resources. Once drafted, discharge plans are reviewed and adjusted as needed with each subsequent clinical review prior to the member's discharge from the facility. In instances where a member who is enrolled in our care management program is admitted to an inpatient facility, our concurrent review staff immediately notifies the member's care manager.

We continue to promote increased support for discharge planning as a critical component to reducing readmission rates. Some strategies we have launched recently include an assessment at the time of admission to identify members most likely to readmit based on algorithms considering their conditions and past utilization history. Those identified at risk are provided additional discharge supports that can include in-hospital visits by a WellCare care manager to arrange for appropriate discharge

Care Gap Monitoring and Reporting

One way to help members prevent unnecessary utilization of more restrictive levels of care is to ensure they have a positive and ongoing preventive relationship with their PCP. To foster these relationships, we have built a disciplined approach to monitoring for care gaps, working with members to close care gaps and reporting care gaps to providers to support their efforts to close those gaps. We offer in-person support to our PCPs to review care gap reports and make reports available online in a secure provider portal. We continue to enhance these efforts and two of our newest initiatives includes mapping of care gap reports to identify geographic trends as well as pro-active member outreach when care gaps are identified to walk them through the gap and facilitate a three-way call with their PCP office to set an appointment to close the identified gap.

Promotion of Patient-Centered Care through PCMH Model

Members in medical homes tend to have closer connections with their primary care providers, which helps them meet their health care needs in the least restrictive and cost-effective settings. Because of this, we support MLTC's effort to grow the number of PCMH-designated practices in Nebraska and have offered a number of strategies to promote this effort including technical support, incentive-based payment structure, collaboration on care coordination and data information sharing.

Ensuring Care is Provided in the Most Appropriate and Cost-Effective Setting

WellCare's UM protocols, including those for inpatient stays, coupled with our nationally-recognized clinical review criteria and our concurrent review program help ensure care is provided to our members in the most appropriate and cost-effective settings.

WellCare's Prior Authorization Rules Help Ensure Admissions are Appropriate

Prior authorization is an effective way to help ensure care is provided in the most appropriate and cost-effective setting. While WellCare does not require prior authorization for emergency and post-stabilization services or crisis stabilization services, authorizations are required for inpatient confinements including:

- Elective inpatient
- Acute inpatient
- Skilled nursing
- Behavioral health
- Rehabilitation/residential
- Long-term/sub-acute care

Concurrent Review and Review Criteria Reduce Avoidable Hospital Days and Readmissions

Concurrent review is an essential component of our UM program as well as an integral part of our Care Management (CM) program. Upon notification that a member has been admitted to a facility, our intake team initiates the authorization and routes the admission to the designated concurrent review staff for that facility. The concurrent review professional carefully reviews the member's clinical information contacting the facility if additional information is needed. In addition to reviewing the clinical information related to the member's current admission, the concurrent review staff also has available all information about the member within our clinical systems including prior inpatient stays, pharmacy claims, case notes, and care plans.

From there, our concurrent review staff provides highly-individualized, person-centered support to our members through a mix of onsite, telephonic, or faxed clinical review and communication with the attending physician, facility clinical staff, care coordinator, and any other health care professionals involved in the member's care. In facilities where we staff onsite concurrent review professionals, our staff will be at the member's bedside for the initial screening, which is completed during the admissions review. Our experience has demonstrated the significant value of face-to-face contact with the member and family member or caregiver in allowing for a more comprehensive identification of and planning for discharge-related needs. Our onsite staff also provide patient and family education, care planning,

medication review, identification of community resources, and coordination of follow-up care and non-emergency transportation, if necessary. Our staff also leverages our proprietary Health*Connections* model, which helps connect members to social services including financial, food, education and utility assistance, transportation, disability and homeless services.

ADDRESSING ACCESS TO PRIMARY CARE SERVICES

WellCare uses a multi-faceted approach to promote and facilitate patient-centered primary care. Our approaches are tailored based on where providers are starting from in terms of their capacity for patient-centeredness. Generally, the layers of support we offer, based on provider need, include:

- Clinical practice support and training through our clinical HEDIS practice advisers (CHPAs), medical director, pharmacy director, behavioral health manager, quality management coordinator, medical management coordinator, care managers, disease mangers, and utilization managers as well as the ongoing support of our provider services representatives, operations account representatives, and CommUnity advocates
- Sharing of data and analytics including:
  - Quality dashboard with HEDIS scores, care gap reports, and quality trends
  - Measures of provider efficiency such as use of electronic funds and electronic data interchange
- Information technology (IT) infrastructure such as assistance with health information exchange (HIE) connectivity and electronic health record (EHR) support
- Care managers who educate members and partner with providers to ensure appropriate medically-necessary services are delivered to the member
- Disease managers who provide health education and chronic disease health coaching to members
- CommUnity Assistance Line offering connections to community resources to help address social barriers and needs through our award-winning proprietary Health*Connections* model
- Member incentives and education programs to support healthy behaviors, member empowerment and member engagement in their own health care
- Centralized telephonic outreach program with outreach specialists who contact members with identified care gaps and initiate a three-way call with the member's provider to help set-up an appointment to close the care gap
- Member engagement unit that outreaches to members about recent emergency department visits to reconnect them to their PCP and conducts discharge follow-up
- Integrated system of care focused on the collaboration of behavioral health providers with PCPs, service providers, hospitals and consumer/peer providers

Additional strategies we will deploy in Nebraska to promote access to primary care include:

- **Creating Access to Medical and Health Homes:** Upon contract award, WellCare will implement our Nebraska Patient Centered Medical Home (PCMH) program. In addition to aligning members with provider practices that have attained PCMH recognition, WellCare of Nebraska will increase the number of smaller provider practices attaining PCMH recognition. Our PCMH program provides a spectrum of resources to interested providers, from educational sessions about PCMH concepts, to coaching assistance in helping interpret PCMH recognition requirements and reviewing documentation for a successful recognition. This program facilitates awareness of the PCMH recognition program and helps providers decide if they are ready to pursue PCMH recognition.
- **Rewarding Members for Establishing a Relationship with Their Primary Care Provider:** WellCare's Healthy Rewards Program encourages personal responsibility by rewarding members who complete specific preventive health, wellness and engagement milestones with a reloadable

Healthy Rewards debit card. The Healthy Rewards debit card is credited with dollars upon completion of specific activities and services, including an initial visit with their primary care provider within the first 90 days of their enrollment, which is important in creating a positive relationship with their provider.

- **Enabling Care Through a Telehealth Program:** Telehealth provides a tangible, impactful way to expand access to care for members in areas that have few providers or in instances where a member has difficulty traveling to be seen. Among its many benefits, telehealth increases access to specialty care for patients in rural and frontier areas, decreases travel time and saves money for patients and caretakers. To that end, we will promote telehealth services in Nebraska through three primary avenues:
  - Developing reimbursement methodologies to make it worthwhile for providers to use existing technologies to conduct telehealth such as reimbursement for the hosting site
  - Helping support, through grant funds, the development of new telehealth sites in remote areas where such services don't currently exist
  - Providing for the technology to support direct provider to member care using telehealth technologies, such as Cobalt Therapeutics, an online tool for members to access Cognitive Behavioral therapy and self-management tools; or through our relationship with American Well, a telehealth company that provides a network of available providers online 24/7.

Strategies to Promote the Use of Urgent Care Centers and Retail Clinics

As part of our network development efforts, we will work diligently to include urgent care centers and retail clinics in our network. As we do in our affiliate Medicaid plans, we will make it easy for members to locate participating centers in our printed provider directories, through our Find-a-Provider tool on the Member Portal and through our MyWellCare mobile application. WellCare of Nebraska members will be able to download our MyWellCare application to their Apple or Android device to have easy access to a number of important plan details including our Find-a-Provider tool and Quick Care (urgent care locator). Additionally, the 24-hour nurse line will refer members to urgent care centers if the clinical guidelines drive toward that solution for members after hours.

Strategies to Address Super-Utilizers Including Members with Asthma, Diabetes, Chronic Pain, and Behavioral Health Conditions

Tracking utilization and intervening with Care Management

The key to addressing "super-utilizers" with multiple chronic conditions is found in our care management model. All members are stratified based on their utilization patters and health conditions. Those with the most acute needs are further assessed and placed into various levels of care management, up to and including, in-person field-based care management where dedicated and specially trained staff meet members in their homes, nursing facilities, rehab facilities or wherever they are to develop a care plan with the primary goals of improved health outcomes and enhanced quality of life, which naturally lead to less utilization of unnecessary hospital and emergency department services.

As part of our processes, we regularly track members' utilization and identify outliers who need additional interventions. WellCare's Medical Directors conduct regular clinical rounds for members where data shows them as outside of norms. Our concurrent review nurses and behavioral health professionals, care managers, pharmacy staff and others as needed participate in the meetings. The team discusses members' cases including those whose length of stay is greater than 14 days, NICU babies, those with complex medical needs, those with frequent admissions, and those with barriers to discharge, and seeks to find interventions to help maintain them in their homes and communities.

Disease Management Programming

The WellCare Disease Management Program is designed to be complimentary and supportive to our

members. A member may be referred directly to the Disease Management Program or referred upon completion of the short-term or Complex Case Management Programs. The Disease Management Program staff has full view of the member's assessments, case notes and health care claims to deliver education, guidance and support for the primary chronic condition for which a member may need additional support. The six key chronic conditions that are addressed in the Disease Management Program are:

- Asthma
- Coronary Artery Disease,
- Congestive Heart Failure
- Diabetes and
- Hypertension
- Chronic Obstructive Pulmonary Disease

Disease Management Program members are offered supportive disease specific educational materials written in easy to understand language for better management of their condition. Upon completion of the Disease Management Program, the member is offered supplemental condition specific mailings twice a year via mail as long as desired.

Strategies to Address Members with Behavioral Health Conditions

In addition to our targeted care management program for members with Severe Mental Illness or Serious Emotional Disturbance, we will offer a variety of interventions including:

- ***24-Hour Behavioral Health Crisis Line:*** WellCare will provide members with access to a 24-hour behavioral health crisis line. Should a member contact the 24/7 Behavioral Health Crisis Line, the call will be answered by a specially trained, non-clinician, within established time frames for call handling. If the call is a true crisis call, a behavioral health clinician will immediately join the call to assess, support and manage the situation for the most timely and effective outcome for the member in need.
- ***Homeless Outreach:*** WellCare will collaborate with local community based organizations to create additional services such as behavioral health assessments, parenting support, group therapy, nutritional education and medical access that impact retention rates and wait times of homeless community members. The focus of the interventions will be on increasing the longevity of stabilization and evaluating the impact of health outcomes.
- ***Cobalt Therapeutics:*** WellCare provides free, confidential online cognitive behavioral therapy through the COBALT Therapeutics Program. COBALT is a web-based program that offers a portfolio of behavioral health self-management tools for a variety of conditions. The use of COBALT has been shown effective in engaging members in appropriate self-care by reducing self-destructive cognitive and behavioral patterns caused by depression, anxiety, insomnia and substance use.

SECTION IV.N UTILIZATION MANAGEMENT

89. Describe the MCO's proposed MTM program, including a description of the inclusion criteria that the MCO proposes to use. Also, include any vendor(s) that will be subcontracted by the MCO to perform or support MTM services. Provide a detailed description of tools the MCO will use to ensure the active engagement of the retail pharmacies in the MTM program. *(Page limit 4 pages)*

IMPROVING POPULATION HEALTH THROUGH OUR MEDICATION THERAPY MANAGEMENT PROGRAM

For over 20 years, WellCare has been entrusted to ensure safe and effective medication use among our Medicaid members. Developed in cooperation with licensed and practicing pharmacists and physicians, our medication therapy management (MTM) program, The Healthy Living Program, is designed to proactively identify members who may be at risk of experiencing potential drug therapy problems, such as side effects, and help prevent these problems from occurring. Through a proven combination of person-centered interventions targeted at prescribers, pharmacists, members, and other health care professionals, we help members live healthier, feel better, and take active control of their health.

WellCare offers a variety of programs to meet the needs of our diverse Medicaid members. Each of these programs is designed to meet specific programs goals and objectives but our general framework includes:

- Adoption of nationally-recognized clinical guidelines
- Use of evidence- and outcomes-based care processes
- Personal consultation with pharmacists and prescribers
- Targeted member education about potential drug therapy problems and medication safety
- Access to online health and medication resources through our member portal
- Access to our 24 hour nurse help line, where members can ask questions about prescription and over-the-counter medications, herbal supplements, and/or health conditions

Advancing the Care of our Members Through Improved Medication Use

In 2014, we successfully decreased antipsychotic polypharmacy over 62 percent through our Antipsychotic Medication Therapy Management Program in our affiliate Medicaid plan in Florida.

WELLCARE'S PROPOSED MTM PROGRAM FOR NEBRASKA HERITAGE HEALTH MEMBERS

Medicaid beneficiaries, especially those with disabilities, are more likely to have chronic conditions. When not properly cared for and managed, these members experience higher utilization of emergency and acute care facilities and higher rates of hospitalization. While medication is a cost-effective way to manage many chronic conditions, three out of four people with chronic conditions are not on optimal therapy. Upon contract award, we will implement an MTM program in Nebraska. Our program will be based on our experience with MTM programs as well as our existing framework but modified to meet the needs of Nebraska Heritage Health members. Our MTM program will feature the following components:

- **Psychotropic Medications Program:** This program provides targeted provider outreach and education regarding members who may be chronic over-utilizers of multiple antipsychotics as well as those with inappropriate use of antipsychotics based on age or diagnosis.
- **Core Safety and Monitoring Program (Medications at Risk of Abuse):** This program provides active, continuous identification of potential fraud, waste, and abuse through retrospective review of and stratification of questionable utilization profiles. Usage information is sent directly to prescribers with case referral to our special investigations unit for follow up.

- **Medication Adherence Program:** This program provides individualized, tailored provider messages to promote optimal adherence for members with any one of eleven targeted prevalent and costly medical conditions.
- **Gaps in Care Program:** This program targets physicians of members diagnosed with any one of six designated chronic conditions that are best managed with combination therapy providing timely physician alerts to help ensure members are on all necessary medications.
- **Polypharmacy Program:** This program uses clinical pharmacists to identify members who are high utilizers of medications, including dual eligibles, and provides clinical pharmacy intervention in order to prevent and/or resolves drug therapy problems related to appropriate medication use, indication, safety, effectiveness and compliance.
- **ADHD Medication in Children Program:** This program targets members receiving ADHD medications and their physicians to ensure appropriate medication use and follow up in accordance with nationally-recognized, evidence-based guidelines for ADHD.
- **Medication Reconciliation:** Through this medication therapy management program, our clinical pharmacists and concurrent review professionals work with members who are hospitalized and reconcile their medications as a part of our approach to comprehensive discharge planning.

Helping Children Prescribed ADHD Medications

Through an effective combination of provider education, clinical support tools, and member engagement, our affiliate Medicaid plan in Kentucky improved management of members prescribed ADHD medications by nearly 4 % points in two years.

Inclusion Criteria for Our MTM Program: Identifying Members with Complex Medication Regimens

As outlined in **Figure 7** below, each MTM program features a specific set of inclusion criteria based on the program's focus. Once the inclusion criteria is defined, we implement scheduled queries to automatically mine our pharmacy and medical claims data to identify members who qualify for our MTM programs.

Figure 7

CRITERIA FOR INCLUSION IN WELLCARE'S MTM PROGRAM	
Program	**Critreia**
Psychotropic Medications Program	Enrolled with WellCare at least 90 calendar days with more than two prescriptions for antipsychotic medications within a 90 day period OR two or more prescriptions for antipsychotics medications related to dementia, OR two or more prescriptions for antipsychotic medications for members greater than 65 years of age
Core Safety and Monitoring Program (Medications at Risk of Abuse)	Uses a proprietary algorithm to identify members with suspicious behavior patterns including high number of controlled substance claims, multiple prescribers of controlled substances, prescriptions filled at multiple pharmacies, excessive utilization, geographic distribution of controlled substance prescribers and pharmacies, or high total claim costs
Medication Adherence Program	Members diagnosed with behavioral health conditions (i.e., depression, schizophrenia), benign prostatic hypertrophy, breast cancer, coronary artery disease, diabetes, heart failure, high cholesterol, hypertension, steoporosis, Parkinson's disease, or respiratory diseases (i.e., asthma)

Gaps in Care Program	Members diagnosed with coronary artery disease, diabetes, heart failure, osteoporosis, respiratory diseases, or rheumatoid arthritis
Polypharmacy Program	Enrolled with WellCare with prescriptions for ten or more chronic medications over a 90 day period
ADHD Medication in Children Program	Members 3 to 18 years of age who have been dispensed an ADHD medication including CNS stimulants alpha-2 receptor agonists, and miscellaneous ADHD medications
Medication Reconciliation	Members who are hospitalized who are at high-risk for post-discharge complications due to their medication profile

The above MTM programs include coordination among WellCare, the member, the pharmacist, and the prescriber using various means of communication and education. Our outreach is designed to enhance members' understanding of their prescriptions and engage them in education about their medication and efforts to improve their compliance with their prescribed medication regimens. Our outreach also educates members about how to effectively communicate their preferences and needs with their prescribers to promote shared decision-making, which empowers members to have greater personal responsibility for their health care.

Our MTM program features robust data collection and analysis of pharmacy-related health and health care delivery data for WellCare members so we may continually measure progress of our programs and, more importantly, the health outcomes of those we serve. This will be expanded to include Nebraska. We objectively evaluate the effectiveness of our interventions in their ability to achieve desired outcomes. This critical analysis allows us to identify opportunities to improve our program design and thereby increase performance outcomes and, overall, improve of our MTM model of care. WellCare commits to submitting an annual report to the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care's (MLTC) that describes our MTM program activities, the relative effectiveness of our MTM program's efforts over the reporting period, and our activities planned for the next reporting period.

WellCare's Use of Subcontractors to Supplement our MTM Programs and Services

Guided by Exceptional Leadership

Our Senior Director, Pharmacy Clinical Programs who oversees our MTM program is one of only 845 Board Certified Psychiatric Pharmacists in the world and serves on a national MTM Technical Expert panel.

Our MTM program is managed internally by our specially-trained, highly-qualified pharmacy team, which includes our Chief Pharmacy Officer, Director of MTM Services, and Pharmacy Managers. **Over 80 percent of WellCare's MTM clinical pharmacists have successfully completed the American Pharmacists Association's certification training program for Delivering Medication Therapy Management Services.** This innovative and interactive certificate training program explores the pharmacist's role in providing MTM services and teaches pharmacists the essential skills necessary to become a successful MTM practitioner. The certificate training program enhances pharmacists' clinical expertise in evaluating complicated medication regimens, identifying medication-related problems, and making recommendations to patients, caregivers, and health care professionals. In addition to having pharmacists certified in MTM services, our MTM staff includes a Board Certified Pharmacotherapy Specialist and a Board Certified Psychiatric Pharmacist. Board certification through the Board of Pharmacy Specialties is recognized as the gold standard for determining which pharmacists are qualified to contribute at advanced practice levels. Our team also includes two Clinical Geriatric Practitioners. Geriatric pharmacists are specially trained to focus on the total patient, looking at all of the diseases and all of the medicines to evaluate appropriateness of drug therapy. The geriatric pharmacist is also trained to know that the elderly are subject to conditions, such as falls, delirium, and cognitive impairment and drug therapy must be

evaluated with respect to the potential for medications to cause or worsen "geriatric syndromes." WellCare will use our pharmacy benefit manager to supplement our MTM programs and services including the Core Safety and Monitoring, Gaps in Care, and Medication Adherence Programs.

WELLCARE'S TOOLS TO ENGAGE RETAIL PHARMACIES IN IMPROVING MEDICATION USE IN OUR MEMBERS WITH COMPLEX MEDICATION REGIMENS

We use a variety of tools to engage our retail pharmacies in improving medication use in our members with complex medication regimens. Consistent with existing best practices, our pharmacy claims processing system assesses each active drug regimen for members in terms of ingredient duplication, therapeutic duplication, drug/drug interactions, drug/age contraindications, drug/gender limitations, drug/pregnancy contraindications, drug/disease contraindications, over- and under-utilization, incorrect dosage or duration of drug treatment, clinical abuse or misuse, and other clinically-appropriate evaluations. By applying prospective drug utilization criteria we engage pharmacies at the point of sale (POS) using National Council for Prescription Drug Programs (NCPDP) telecommunications standards to message the pharmacy network about preferred alternative medication(s), quantity limits, and use of generics whenever available and therapeutically appropriate.

In addition, we engage retail pharmacies through real-time screening and application of our DUR criteria, to identify potential adverse drug events for every prescription adjudicated. The system monitors prescription claims for potential problems against pharmacy and medical information and returns an alert, when appropriate, via the online POS claims adjudication system. Examples of edits include therapeutic dose (monitoring medications' total daily dose based upon FDA maximum daily dosing limits), drug-drug interaction screening (monitoring members' prescription history for interaction between two drugs), and duplicate therapy screening (monitoring for duplication of same medication classes). When a potential conflict is identified, an interventional message is delivered to the pharmacy real-time to engage them. Alerts include:

- **Messaging:** Alerts to network pharmacy during prescription processing to inform the pharmacist of a potential drug conflict.
- **Soft Messaging:** Our override-able alerts to the network pharmacy at the POS. Pharmacists are required to review the potential medication conflict, take action, and enter standard NCPDP conflict, intervention, and outcome codes for prescription adjudication.
- **Hard Messaging:** Does not allow an override at the POS; the pharmacist contacts us to provide appropriate information to receive override.

In addition to the above tools, WellCare will use EQuIPP (Electronic Quality Improvement Platform for Plans and Pharmacies) to ensure active engagement through retail pharmacies in our MTM program. EQuIPP is a web-based, performance information management platform that makes unbiased, benchmarked performance data available to both health plans and community pharmacy organizations. EQuIPP allows us to better understand the impact that our pharmacy providers have on the quality of care delivered to our members by packaging benchmarked performance information, based on accepted quality measures, in user-friendly dashboards within the EQuIPP platform. The state-of-the-art EQuIPP solution, brings a level of standardization to the measurement of the quality of medication use, and makes this information accessible and easy to understand. By doing so, EQuIPP facilitates an environment where WellCare and our contracted pharmacies can engage in strategic relationships to address improvements in the quality of medication use for our members. And because EQuIPP is a web-based solution, our contracted pharmacies will not need to invest in any special hardware, software, or resources other than internet access, which they would already have in place, making for ease of implementation.

SECTION IV.N UTILIZATION MANAGEMENT

90. Describe the MCO's DUR program including prospective and retrospective DUR activities. Include a description of:

- Prescriber and pharmacy education programs.
- Collaboration with MLTC's DUR.
- How DUR results will be used to inform MTM education and outreach.

(Page limit 3 pages)

WELLCARE'S DRUG UTILIZATION MANAGEMENT PROGRAM ENSURES APPROPRIATE MEDICATION DECISION-MAKING AND POSITIVE HEALTH OUTCOMES

WellCare's Drug Utilization Review (DUR) program provides members with the best quality prescription drug benefit at the lowest possible cost while ensuring members are given appropriate access to medically-necessary drugs in a timely manner. Our program, which is under the direction of our DUR Committee and our Pharmacy and Therapeutics (P&T) Committee, features a comprehensive review of our members' pharmacy data prospectively, concurrently, and retrospectively to dispensing to ensure appropriate medication decision-making and positive health outcomes. Our DUR programs include corrective action, prescriber feedback and further evaluations. We acknowledge our requirement to submit guidelines for our DUR program to the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care's (MLTC) for review and approval at least 60 calendar days prior to the contract's start date as well as any intended implementation of changes.

WellCare's Prospective Drug Utilization Review Activities Deliver Cost-Effective Utilization

Our pharmacy benefit manager's (PBMs) pharmacy claims system provides a central electronic repository for capturing, storing, and updating prospective DUR data. Consistent with existing best practices, the claims processing system assesses each active drug regimen of members in terms of ingredient duplication, therapeutic duplication, drug/drug interactions, drug/age contraindications, drug/gender limitations, drug/pregnancy contraindications, drug/disease contraindications, over- and under-utilization, incorrect dosage or duration of drug treatment, clinical abuse or misuse, and other clinically-appropriate evaluations. Our prospective drug utilization activities include, but are not limited to, step therapy, quantity limits, prior authorization, and generic utilization.

Figure 8

As noted in **Figure 8** our PBM implements our prospective drug utilization management tools at the point of sale (POS) for our 70,000 contracted pharmacies nationwide by using National Council for Prescription Drug Programs (NCPDP) telecommunications standards to message the pharmacy network about

- Preferred alternative medication(s)
- Quantity limits
- Use of generics whenever available and therapeutically appropriate

WellCare's Concurrent Drug Utilization Review Activities Reasonably and Appropriately Reduce Health Care Costs

Our PBM maintains a profile of each member's medication history, consisting of all pharmacy claims submitted to them by any pharmacy provider. Through real-time screening and application of our DUR criteria, our PBM identifies potential adverse drug events for every prescription adjudicated. The system monitors prescription claims for potential problems against pharmacy and medical information and

returns an alert, when appropriate, via the online POS claims adjudication system. Examples of edits include therapeutic dose (monitoring medications' total daily dose based upon FDA maximum daily dosing limits), drug-drug interaction screening (monitoring members' prescription history for interaction between two drugs), and duplicate therapy screening (monitoring for duplication of same medication classes). When a potential conflict is identified, an interventional message is delivered to the pharmacy real-time to alert them. Alerts include:

- **Messaging:** Alerts to network pharmacy during prescription processing to inform the pharmacist of a potential drug conflict.
- **Soft Messaging:** Our override-able alerts to the network pharmacy at the POS. Pharmacists are required to review the potential medication conflict, take action, and enter standard NCPDP conflict, intervention, and outcome codes for prescription adjudication.
- **Hard Messaging:** Does not allow an override at the POS; the pharmacist contacts us to provide appropriate information to receive override.

Each month we receive summary and detail reports from concurrent review DUR activity. The data is evaluated by our DUR Committee. Annually, our DUR Committee reviews each class of DUR edits for trends and potential program enhancements.

Driving Clinical Quality Through our Retrospective Drug Utilization Review Activities

Our retrospective DURs (rDURs) are executed with routine examination of claims data and other records, through computerized drug claims processing and information retrieval systems to assess the clinical quality of prescribing and dispensing of our formulary medications. Our rDUR criteria are designed to identify patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists, and members associated with specific drugs or groups of drugs. WellCare performs retrospective DUR projects throughout the year to improve the quality of health services provided to our members. We acknowledge MLTC's requirement to perform, at a minimum, one rDUR intervention each quarter. Based on our historical activity, we will exceed that requirement. For example in 2014, we performed seven rDURs, examples included *Evaluation of Potentially Significant Drug Interactions in Members Taking Sofosbuvir* and *Duplication of Therapy of Acetylcholinesterase Inhibitors*. In 2016, we are enhancing our rDUR to include Retrospective Safety Review within 72 hours. Through this program clinical pharmacists will review flagged claims within 72 hours of adjudication sending alerts to prescribers requesting a response. In severe cases, the clinical pharmacist will call the pharmacy or prescriber directly.

Prescriber and Pharmacy Educational Intervention Program

Our Pharmacy Network Improvement Program (NIP) targets physicians and provides education on pharmacy utilization and cost trends as well as quality care gaps related to medication prescribing and adherence. Our local Pharmacy Directors use physician prescribing reports, evidence-based drug therapy, face-to-face visits, and telephonic communication to modify prescribing behaviors with the intent to improve the quality of care for our members in the most cost-effective manner. A physician's pharmacy cost per member per month (PMPM), prescriptions per member per month (SPMPM), generic dispensing rate (GDR) as well as targeted high-cost, non-formulary and utilization of non-first-line agents are evaluated against the state or region-specific benchmarks and discussed in-depth with the physician in an open dialogue format. We educate physician on key pharmacy resources such as the preferred drug list, prior authorization, and our web-based drug search tool. The State Pharmacy Directors also provide on-going follow up and assistance on any prior authorization or adjudication issues or questions.

We use an academic detailing framework to conduct interactive physician education providing unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions. It is usually provided to clinicians one-on-one in their own offices. The approach is structured to provide practitioners with neutral, rigorous information to optimize their clinical decision-making. Detailers

provide clinical outreach education information interactively to health care providers in one-on-one settings. This education synthesizes up-to-date evidence about comparative efficacy, safety, and cost-effectiveness of commonly used therapies or medical practices. Communication techniques include using principles of social marketing to gain commitment to behavior change. This academically-based "detailing" represents a useful and cost-effective way to improve the quality of drug-therapy decisions and reduce unnecessary expenditures. Each of our Directors, State Pharmacy, completes at least 25 visits per month often to multi-prescriber offices.

WellCare manages a robust Pharmacy Lock-In program for those members whose pharmacy utilization patterns are excessive and inappropriate. The program is designed to provide controls over which pharmacy the members can access and provide appropriate referrals to case management, thereby improving quality and safety of care, providing continuity of medical care, minimizing duplicate therapy or excessive drug quantities, and reducing unnecessary or inappropriate physician, pharmacy, and/or emergency room services. There are several ways in which we identify members as potential candidates for the Lock-In program including rDUR of pharmacy claims data, physician referral, and pharmacist referral. Once a member has been identified as potentially benefiting from our Pharmacy Lock-In program, we conduct an analysis of pharmacy claims data to determine the appropriateness of pharmacy utilization. If the patterns are appropriate and medically-justified, no further action is taken. If, however, the patterns demonstrate inappropriate utilization, interventions are initiated. Interventions include enrolling the member in a pharmacy or physician lock-in program, physician outreach, member outreach, and member referral to care management.

WellCare's Commitment to Collaborating with MLTCs DUR

As part of our commitment to ongoing collaboration with MLTC's DUR, on a quarterly basis we will submit documentation needed to support preparation of MLTC's annual CMS DUR report. We will also nominate a non-voting staff member to attend the Nebraska Drug Utilization Review Board meetings. We acknowledge that we must obtain MLTC's written approval of our nominee. WellCare will leverage our engagement in the DUR Board meetings as vehicle to provide input into MLTC's DUR as well as to identify directives or ideas that can implemented by WellCare.

Using Results of Reviews to Inform MTM Education and Outreach Needs

WellCare maintains highly integrated DUR and Medication Therapy Management (MTM) programs. Our Sr. Director of Clinical Programs oversees our MTM program and is a voting member of our DUR Committee. Our DUR Committee identifies opportunities to improve medication utilization by assessing a combination of claims- and outcomes-based data. The DUR Committee, including our MTM staff, identifies specific ways they can apply pharmacy claims data to identify members at risk of experiencing potential drug therapy problems (i.e., side effects, drug interactions). Our MTM team then designs programs based on inputs from the DUR Committee and begins engaging members, physicians, and pharmacists in population health-based interventions. The MTM team provides process and outcomes reporting back to the DUR Committee to measure program effectiveness. In addition, certain DUR projects may include recommendations for outreach by our MTM team, outside of their standard medication review processes. For example, based on a DUR on a therapeutic class or disease state, we may identify areas of more appropriate drug therapy. If the DUR committee approves outreach to physicians and/or members based on this drug utilization review, the MTM team implements the initiative again providing process and outcomes reporting to the DUR Committee.

SECTION IV.N UTILIZATION MANAGEMENT

91. Describe the MCO's proposed psychotropic drug oversight program to ensure appropriate utilization, including a description of the inclusion criteria that the MCO proposes to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of:

- Tools to monitor and measure psychotropic prescribing patterns and usage.
- Processes to actively engage retail pharmacies and pharmacists in the oversight program.
- Plans for prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member.
- Processes to ensure that psychotropic medications prescribed to children are being used appropriately and for the indicated diagnosis.

(Page limit 4 pages)

Experience and Expertise in Overseeing the Use of Psychotropic Medications

WellCare serves nearly 281,000 members on psychotropic medications, representing 12 percent of our Medicaid membership nationally and over 25 percent of our Medicaid members with prescriptions. As a fully-integrated medical, behavioral, and pharmacy services managed care organization, we offer significant experience and expertise serving those diagnosed with mental health conditions and in ensuring appropriate use of psychotropic medications. We also serve a significant role in preventing misuse of these often powerful drugs.

Our comprehensive psychotropic drug oversight program uses evidence- and outcomes-based processes to ensure appropriate utilization across a variety of medications including antipsychotics, antidepressants, and medications for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Our program is under the direction of our Pharmacy & Therapeutics (P&T) Committee, which includes a psychiatrist in its membership, and is executed through our local managed care operations teams, our national in-house behavioral health care management and pharmacy teams, and our pharmacy benefit manager (PBM).

Expanding Our Psychotropic Drug Oversight Program to Meet Nebraska's Needs

Upon contract award, we will implement a comprehensive psychotropic drug oversight program. Our program will be based on our existing framework and best practices and modified to meet the specific needs of Nebraska's Heritage Health members. The program, based on nationally-recognized guidelines including the U.S. Food and Drug Administration (FDA) and Micromedex, will feature training and education, ongoing data collection, and real-time surveillance systems to identify high-risk cases including those potentially over-reliant on psychotropic medications, including children and adolescents in foster care. Our comprehensive program will offer an array of member and provider interventions aimed at improving healthcare quality and reducing costs. Components of our program will include:

Advancing the Care of our Members Through Improved Medication Use

In 2014, in our affiliate Medicaid plan in Florida, we reduced antipsychotic polypharmacy over 62 percent through our Antipsychotic Medication Program.

- **Children Dispensed ADHD Medication:** This program targets members receiving ADHD medications and their physicians to ensure appropriate medication use and follow up in accordance with nationally-recognized, evidence-based guidelines for ADHD.
- **Medication Adherence Program:** This program provides individualized, tailored provider outreach

to promote optimal adherence for members diagnosed with one of eleven targeted prevalent and costly medical conditions including those diagnosed with depression or schizophrenia.

- **Members Prescribed Psychotropic Medications:** This program provides targeted provider outreach and education regarding members who are chronic over-utilizers of multiple antipsychotics as well as those with inappropriate use of antipsychotics based on age or diagnosis.

Under our program, we will require prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in the RFP. We will also ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist, when indicated. Through our program, we will manage the prescribing of psychoactive medications to members age 20 and under by:

- Measuring psychopharmacology usage and prescribing patterns
- Monitoring the use of, and the claims related to, psychopharmacology to identify target populations (e.g., age subsets) for proposed interventions
- Preparing member-specific profiles of medication use to inform our interventions with prescribers
- Developing prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member

As part of our implementation, we will continue to oversee, monitor, and assist with the management of our PBM's activities related to the use of mental health drugs for children, including the establishment of prior authorization criteria, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18. This will include maintenance of point of service (POS) system edits as outlined in Attachment 8 of the RFP.

We will submit reports to MLTC detailing approvals and denials of psychotropic medication requests for youth. Our reports will use the eligibility categories provided to us via the enrollment files and will be submitted as specified in the RFP. As we do in our affiliate Medicaid plans, we will actively participate and collaborate with inter-agency workgroups and initiatives, when requested by MLTC. We will provide recommendations for how MLTC can influence regulatory and legislative changes or redesign healthcare to improve the quality of care and costs associated with the use of psychotropic medications.

Proposed Inclusion Criteria to Monitor Appropriate Use of Psychotropic Medications

As outlined in **Figure 9** below, each component of our psychotropic drug oversight program features specific inclusion criteria based on the program's focus. Using the defined criteria, we implement the specifications within our real-time surveillance systems to mine pharmacy and medical claims data to identify members, pharmacies, and prescribers to target through our program.

Figure 9

Criteria for Inclusion in WellCare's Psychotropic Drug Oversight Program	
Program Component	**Criteria**
ADHD Medication in Children Program	Members three to 18 years of age who have been dispensed an ADHD medication defined as CNS stimulants, alpha-2 receptor agonists, and miscellaneous ADHD medications
Medication Adherence	Members diagnosed with depression and schizophrenia
Psychotropic Medications Program	Members with more than two prescriptions for antipsychotic medications within a 90 day period OR two or more prescriptions for antipsychotics medications related to dementia, OR two or more prescriptions for antipsychotic medications for members greater than 65 years of age

WellCare's Tools to Monitor & Measure Prescribing Patterns and Usage

Our proprietary Pharmacy Toolbox is central to our psychotropic drug surveillance efforts. Each month our Pharmacy team uses our Pharmacy Toolbox to monitor and measure prescribing patterns and usage for a variety of pharmacy-related measures including psychotropic medications. As represented in **Figure 10**, our Toolbox reports display utilization, drug evaluation review, and physician data by state for each month as well as year-to-date including

Figure 10

- **Atypical Antipsychotics for Members Under Ten:** Detailed reporting for members under ten years of age prescribed Atypical Antipsychotics (excluding those diagnosed with Autism)
- **Pediatric Prescribing of ADHD Meds:** Detailed reporting for members under 17 years of age using ADHD medications
- **Polypharmacy of Behavioral Health Medications:** Detailed reporting of members who have two or more different antipsychotic medications

Engaging Retail Pharmacies and Pharmacists in Our Psychotropic Drug Oversight Program

Our PBM maintains a profile of each member's medication history, consisting of all pharmacy claims submitted to them by any pharmacy provider. Through real-time surveillance, our PBM identifies potential issues for every prescription adjudicated. The system monitors prescription claims for potential problems against pharmacy and medical information and embedded logic and returns an alert, when appropriate, via the online point-of-service (POS) claims adjudication system to any one of our 70,000 contracted Medicaid pharmacies. When a potential issue is identified, a message is delivered to the pharmacy and pharmacist real-time to alert them. Alerts include:

- **Messaging:** Alerts to network pharmacy during prescription processing to inform the pharmacist of a potential drug conflict
- **Soft Messaging:** Our override-able alerts to the network pharmacy at the POS. Pharmacists are required to review the potential medication conflict, take action, and enter standard NCPDP conflict, intervention, and outcome codes for prescription adjudication
- **Hard Messaging:** Does not allow an override at the POS; the pharmacist contacts us to provide appropriate information to receive override

Plans for Prescriber and Pharmacy Interventions to Reduce Unsupported Atypical Antipsychotic Prescribing and Prescribing of Multiple Medications to the Same Member

The FDA has approved antipsychotics of both classes (FGA and SGA) for the treatment of schizophrenia and bipolar disorder. More recently, some atypical antipsychotics have been approved for indications in major depressive disorder and autism spectrum disorders. Prescribing of the atypicals (SGA) has expanded beyond the approved indications, but their effectiveness, benefits, and adverse effects in off-label uses are not well understood. Additionally, robust evidence is lacking for the effectiveness of antipsychotic polypharmacy. Moreover, significant concerns exist fueled by the fact that most reasons are not justified or supported by data, and there are potential downsides to combining antipsychotics such as high total dosage, increased acute and long-term side effects, drug interactions, increased cost and risk of mortality, as well as increased risk of non-adherence.

Given this, WellCare will apply a variety of population health-based interventions to reduce unsupported atypical antipsychotic prescribing and prevent multiple medications to the same member including the aforementioned POS and

- **Behavioral Health Clinical Practice Guidelines:** WellCare has 14 behavioral health clinical guidelines including Antipsychotic Medication Use in Children & Adolescent, which specifically addresses the use of atypical antipsychotic prescribing in children. These guidelines reinforce the recommendations of leading authorities including the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. These guidelines are reviewed with targeted providers and available for general use via our Provider Portal.
- **Pharmacy Toolbox Reports:** The aforementioned Pharmacy Toolbox reports identify negative trends among prescribers, including antipsychotic polypharmacy as represented in **Figure 11**, and identify specific prescribers for education and training. These reports are used by our local Medical and Pharmacy Directors during one-on-one meetings with prescribers and they are distributed via our Provider Portal.

Figure 11

- **Pharmacy Network Improvement Program (NIP):** Our NIP program is designed to perform targeted prescriber education on pharmacy utilization and cost trends as well as quality care gaps related to medication prescribing and adherence. Our local Pharmacy Directors use prescribing reports to modify prescribing behaviors with the intent to improve the quality of care for our members in the most cost effective manner by promoting quality evidence-based drug therapy and best practices through face-to-face as well as telephonic communication with all of our providers. By applying an academic detailing framework, we conduct interactive educational outreach to prescribers to provide unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions, with the goal of improving patient care. During these sessions we deliver current evidence about comparative efficacy, safety, and cost-effectiveness of commonly used therapies or medical practices and use techniques, include using principles of social marketing, to gain commitment to behavior change.
- **Behavioral Health Homes**: A component of responsibility for Behavioral Health Homes (BHH) is the monitoring of psychotropic medications for their assigned members. For those members whose treatment is being rendered in a BHH, we will provide reports concerning prescribing profiles and monitor their adherence to reducing inappropriate prescribing practices.
- **Targeted Prescriber Outreach:** Targeted written and telephonic outreach to physicians to ensure appropriate medication use and follow up in accordance with nationally-recognized, evidence-based guidelines.

Ensuring Appropriate Use of Psychotropic Medications in Children

In our affiliate Medicaid plan in Hawaii, we implemented rules associated with use of psychotropic medications in children. When a prescription is being filled for a defined set of medications, the system evaluates the prescription against the member's age. If the medication is not indicated, we immediately return a message to the pharmacy indicating so. As an added measure of oversight, when the age rules are satisfied, we require validation against specific ICD-10 codes to ensure the prescription is appropriate for the diagnosis. **As a result of implementing these edits in Hawaii, we have prevented inappropriate use of psychotropic medications for nearly ten percent of members equating to nearly $840,000 in savings annually.** Given our success, we will implement similar measures for Nebraska Heritage Health members so that when a prescription is attempted to be filled for a child or adolescent, there are controls in place based on age and diagnosis. The use of hard messaging will require direct interaction with WellCare in order to adjudicate the claim thereby allowing us to ensure appropriate use for children.

SECTION IV.N UTILIZATION MANAGEMENT

92. Describe the MCO's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities. *(Page limit 2 pages)*

WORKING EVERY DAY TO REDUCE HEALTH DISPARITIES FOR 2.4 MILLION WELLCARE MEDICAID MEMBERS AND THE COMMUNITIES WE SERVE NATIONALLY

WellCare supports the Department of Health and Human Services' (DHHS) Office of Health Disparities & Health Equity (OHDHE) goal to "improve health outcomes of Nebraska's culturally diverse populations with a vision of health equity for all Nebraskans." We have been entrusted to serve 2.4 million Medicaid members nationally and we work tirelessly every day to reduce the burden of societal hardship they face as well as the inequalities seen in preventive health, chronic diseases, behavioral health, and health outcomes.

Through meetings with local providers, community leaders, and individuals in both the family and aged, blind and disabled programs in Nebraska, we understand the significant health challenges facing Nebraska. These challenges, specifically among racial ethnic minorities, Native Americans, and refugees and immigrants, are well-documented in the Nebraska Health Disparities Report produced by OHDHE (**Figure 12**). The following examples demonstrate the significant opportunities to promote health equality among all Nebraskans:

Figure 12

- Nebraska's African American community saw higher rates of infant mortality than the rest of the nation
- Heart disease remains a large problem in the Nebraskan African American and American Indian communities
- Twenty percent of Nebraskan African Americans and Hispanics report they were unable to see a doctor because of cost
- Only about 50 percent of American Indian women received first trimester prenatal care in 2006-2010
- The prevalence of diabetes is increasing with 14 percent of Hispanics diagnosed with diabetes and 13 percent of African Americans and American Indians populations, respectively

Our Methodology to Assess and Correct Health Disparities Among Races and Ethnic Groups

We applaud OHDHE's efforts to be the centralized source for information relevant to the health of minorities in Nebraska. As reflected in our approach and the examples that follow, we are poised to address the specific issues facing Nebraska Heritage Health members experiencing health disparities.

- For our initial assessment of health disparities, we will use the findings from Nebraska Health Disparities Report produced by OHDHE in 2015.
- Using this data, our Quality Improvement and Community Advocacy teams will identify the types and sources of disparities that exist among different cultural groups, including but not limited to racial ethnic minorities and the disabled community, as well as the factors that are influencing health outcomes.
- The findings and recommendations will be presented to our Utilization Management Committee, which will include participating community providers, for input and guidance.
- Multi-disciplinary workgroups comprised of Quality Improvement, Utilization Management, Care Management, Community Advocacy, our Tribal Liaison, and Network Management will design and implement targeted interventions aimed at members, physicians, other health care providers, community-based organizations, and others to eliminate barriers and close identified gaps.

- These teams will continue to work together, along with our Utilization Management (UMC) and Quality Assurance and Performance Improvement Committees (QAPIC) to continually assess the effectiveness of our interventions and ensure we successfully eliminate health disparities creating health equality for all Nebraskans. When race, ethnicity, and cultural variables are available in our systems, our team will apply these additional variables to reports to study trends.

In 2016 we will be enhancing our member identification and stratification criteria to include a number of lifestyle and cultural factors which will further enhance our ability to identify and intervene on factors contributing to health disparities.

Concurrent with the above ongoing activity, we will

- Promote and provide cultural competency training and conduct annual network reviews to ensure cultural diversity statewide, including nationality and language
- Collaborate with public health partners to develop and promote programs and best practices to achieve health equity
- Work in partnership with key stakeholders including local and regional health agencies, other state agencies, tribal entities, faith and community-based organizations to provide training, grants, community-based health activities

Community-Focused Activities to Target Cultural and Racial Disparities

WellCare of Nebraska engages in condition-specific activities in the local community that address cultural and racial disparities in healthcare access. Our approach is highly localized. For example, using the data from the 2010 Road to Health Report produced by the Nebraska Department of Health and Human Services, WellCare of Nebraska identified target locations to engage with our communities to expand the reach of our diabetes related efforts (Refer to **Figure 13** below).

Figure 13

Using this approach across other markets, WellCare has reached 3.9 million stakeholders through nearly 14,000 community activities since November 2011. More than 10 percent of these activities focused on cultures at-risk for the target condition, like diabetes, with the goal to assist members in their local community.

In Georgia, for example, our team is working with a housing complex in Chatham County with a high concentration African Americans with a diabetes diagnosis, many of whom are WellCare members. In partnership with the local Area Agency on Aging, the local chapter of the American Diabetes Association, the Lions Club and others, we are hosting a series of diabetes days, providing education, conducting care management services, A1C testing and more. Through this initiative, WellCare anticipates reaching nearly 300 people.

SECTION IV.O PROGRAM INTEGRITY

93. Describe the MCO's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the MCO has utilized in other states. (*Page limit 4 pages*

VALUING TAXPAYER DOLLARS: THE WELLCARE APPROACH TO PROGRAM INTEGRITY

With more than 20 years of experience solely focused on serving people receiving government-funded health benefits, WellCare has developed a robust set of advanced processes to protect taxpayer dollars. The process begins with establishing a strong administrative structure at the local level focused on program integrity efforts and supplemented by the strength of WellCare's teams across our affiliates and corporate partners dedicated to detecting, investigating and reporting on Fraud, Waste and Abuse (FWA) as well as preventing and recouping any erroneous payments.

A Program Integrity Process that Nets Results

In 2014, WellCare's SIU worked more than 2,300 leads and recovered $4.6 million. From January 1, 2015 through October 31, 2015, the SIU worked more than 2,100 leads and recovered $4 million with another $2 million pending recovery.

WellCare of Nebraska's on-site Program Integrity Officer will report directly to our local Chief Executive Officer and have on-site investigate staff as well as the full support of WellCare's Special Investigation's Unit (SIU). Additionally, we integrate our program integrity activities across all functional areas, so our Program Integrity staff members are supported by clinical, pharmacy and medical staff members, associates conducting quality management activities, member and provider services representatives, claims and coding professionals, auditors and those involved in compliance and regulatory affairs.

WellCare's SIU reports to the Vice President, Corporate Compliance Investigations, who in turn reports to the Chief Compliance Officer (CCO). The SIU maintains written policies and procedures, and adheres to standards of conduct that articulate WellCare's commitment to comply with all applicable federal and individual state standards. The SIU maintains training and education materials specific to FWA, in support of the overall Company Compliance Program, and assists in providing training to employees, business partners, and downstream entities. The SIU promotes the immediate reporting of suspected incidents of FWA by maintaining lines of communication to enable employees, members, providers, business associates and downstream entities to report FWA.

The SIU employs a team of knowledgeable professionals dedicated to detecting, investigating, preventing and remedying FWA. The SIU team includes investigators who collaborate with medical coding auditors and a clinical nurse in order to resolve allegations of FWA on the part of providers or members. The SIU's senior data analyst proactively identifies possible cases of FWA utilizing statistical analysis and data mining software. The SIU also employs business analysts and information case administrators, all of whom assist with case referrals, the case management system, the SIU anti-fraud hotline, respond to requests from government partners, and support the SIU's regulatory reporting responsibilities.

PREVENTING AND DETECTING FWA: WELLCARE'S APPROACH

The SIU uses a multi-faceted approach to combat suspected or potential FWA. This includes a combination of mining data to spot inconsistencies, application of various levels of pre and post-claim edits, leveraging of clinical expertise to identify and confirm unusual trends, follow-up on internal and

external referrals, use of a broad set of investigative tools and skills, and the deployment of education and awareness training program to maximize referrals. **Figure 1** outlines our technologies and strategies for FWA prevention and detection.

The first and most critical step to preventing FWA is provider and member education, where both providers and members are exposed to the basics of what constitutes fraudulent, wasteful or abusive activities as well as how to report and reporting protections. FWA is a topic in our handbooks, on our website, in various training materials and periodically in newsletters and other outreach methods.

Figure 1

WellCare's Technologies and Strategies for FWA Prevention and Detection	
Fraud and Abuse Hotline	The Compliance Department actively promotes timely reporting of suspected incidents of FWA by maintaining lines of communication to enable employees, providers, members, business associates and downstream entities to report FWA anonymously and confidentially to the Compliance Department via the referral mailbox or by calling the SIU hotline at 1-866-678-8355. Our website and manuals also contains information for members, providers and the general public on how to report suspected or known FWA.
Data Mining	The SIU uses data mining technologies to proactively identify potential FWA: ➢ The SIU employs a senior data analyst to conduct targeted claims queries, leveraging the Statistical Analysis System® data network to identify members and providers with suspicious activity or unusual patterns of behavior that might indicate FWA. ➢ We use an FWA analytics library to produce ad hoc reports for the identification and investigation of FWA. These reports include but are not limited to visit trend analysis, provider up-code checker, and hospital stay with no professional services, bell curve analysis and abnormal provider utilization. ➢ The SIU uses COGNOS® business intelligence software to produce a Physician Trend Report by specialty. This report enables the SIU to identify aberrant spikes or trends. When this analysis identifies a provider with suspicious activity, it generates a more detailed set of reports, allowing investigators to view the entire billing and claims history for that provider. ➢ The SIU recently implemented the General Dynamics STARS SOLUTIONS as a new FWA Analytical Tool that provides predictive models and algorithms that identify aberrant patterns and outliers. These outliers are prioritized and forwarded to investigators with the outcome of increased identification of FWA.
Claims System Edits	Claims system edits are designed to detect and prevent potential FWA. These edits include, but are not limited to reviews for: ➢ Member eligibility ➢ Medically unlikely services based on gender or age ➢ Non-covered services ➢ Invalid procedure codes ➢ Duplication of services ➢ Unbundling of services ➢ Frequency of services ➢ Diagnosis matches
Medical Management Activities	Medical Management activities (e.g., prior authorization, concurrent review, discharge planning, retrospective review and Provider profiling) include: 1) verifying Member eligibility; 2) reviewing the medical necessity of the service; 3) determining the appropriateness of the service being authorized; 4) verifying that the service is covered; and 5) referring Members to appropriate Providers. When the prior authorization process identifies FWA, the prior authorization will be denied, a notice of action will be sent to the Member and Provider, and a report will be sent to the SIU. Our SIU reviews, trends, and reports findings to regulators as necessary. In addition, medical management reports allow the SIU department to have multiple points of data to review and

WellCare's Technologies and Strategies for FWA Prevention and Detection	
	verify unusual patterns that may indicate potential fraud and abuse. Any unusual incident is documented and reported as outlined by WellCare policies and procedures.
Provider Services and Quality Improvement Personnel	Provider Services and Quality Improvement personnel are trained to be aware of possible and questionable indicators of FWA so that issues can be identified during routine office visits or medical record reviews. These employees report suspected FWA activities through the SIU for review and further action.
Provider Credentialing	Provider Credentialing prevents contracting with Providers previously found guilty of FWA. We validate the credentials of network Providers as part of initial contacting and we re-credential in accordance with NCQA criteria, and state and federal regulations. As part of this process, we collect and evaluate information about Providers on a monthly basis from a variety of sources (e.g., National Practitioners Data Bank, OIG list of Excluded Individuals or Entities, and applicable state professional licensure boards).
Statistically Valid Random Samples (SVRS) and Audits	WellCare's SIU conducts Statistically Valid Random Samples (SRVS) and audits on a routine basis. These procedures identify and detect inappropriate claims and potential FWA billing.
SIRIS	As a member of the National Health Care Anti-Fraud Association® (NHCAA), WellCare has access to SIRIS, the NHCAA information-sharing website that includes regular postings of information about potential Provider FWA activities by more than 100 insurance companies nationwide. SIU investigators use SIRIS as part of the due diligence they perform in their investigations.

Rooting out Waste, Improving Member Outcomes and Protecting Health Resources

Having observed a potential for a high rate of abuse of the heroin addiction treatment product, Suboxone, we implemented Suboxone Utilization Review and implemented a formulary change to cover Zubsolv. Zubsolv has less buprenorphine than Suboxone with same clinical indications and outcomes. Additionally, a tablet additive makes the buprenorphine in the SL tablet more highly absorbed. The presence of menthol in the tablet formulation makes the product more palatable, but less likely to be abused through injection or "snorting". Zubsolv is also less recognizable on the streets and less likely to be a target for diversion. At the same time we introduced Zubsolv to the formulary, we tightened DER criteria to include requirements for tapering and shortened the length of the DER if tapering was not being documented. ***Through these efforts we successfully reduced the average pharmacy claims per day for Suboxone 40 percent in one year which the savings equate to over $1,600,000 annually.***

Investigating, Confirming and Reporting FWA and Implementing Corrective Actions

Once a potential case of FWA is detected either through a referral or the array of analytical tools we use, WellCare's SIU will pursue investigative actions that may include data analysis, public record reviews, provider onsite audits, interviews and clinical reviews. All suspected cases of FWA will be reported to NMPI as part of our written FWA and erroneous payments compliance plan.

If the potential FWA concerns a member, the inquiry may initially focus on pulling claims data and reviewing it to identify potential FWA, such as inappropriate utilization or card sharing. Following this preliminary analysis, additional investigative steps will be taken which may include obtaining provider records that will be reviewed to identify additional indications of FWA, consulting with experts regarding medical necessity, and interviewing the subjects of the investigation.

The SIU timely reports suspected FWA. Once a determination has been made that FWA has occurred, appropriate remedial action will be pursued. For example, if the FWA concerns a member's drug abuse or doctor/pharmacy shopping, the member may be placed in an approved "lock-in program," which monitors the member's access to medications to help the member in addressing his or her drug dependency.

If the potential FWA involves a provider, the inquiry may initially focus on pulling claims data and reviewing it to identify potential FWA. The provider's records will be requested and obtained for analysis. WellCare of Nebraska's provider agreements will contain language requiring providers to comply with record requests. The review may include engaging medical experts and clinicians to assess medical necessity and review of claims to identify up-coding. These investigative efforts are supplemented by interviews, public records reviews and similar investigative efforts to get as complete and accurate understanding of the issue as possible. Once a determination has been made that a provider has engaged in FWA, remedial actions will be identified, which may include payment suspension, recovery of an overpayment, termination of the provider and referral to law enforcement for prosecution.

Throughout the process, NMPI and MFPAU will be engaged as appropriate and required in WellCare's agreements with MLTC. This includes formal reporting of all tips every two weeks, immediate reporting of allegations being investigated and formal monthly reporting in the format prescribed by MLTC.

Developing a Written FWA and Erroneous Payments Compliance Plan

WellCare will leverage the array of existing FWA plans we have from various states and lines of business as well as corporate expertise in fighting FWA to build a specific Nebraska *FWA and Erroneous Payments Compliance Plan* to meet all the requirements outlined in Section O.8 of the Project Description and Scope of Work of this RFP. In addition to complying with all of the state standards, we routinely incorporate the 2008 "CMS Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit" into our Program Integrity plans.

The plan, which will be finalized and presented to DHS at least 45 days prior to contract start date and by each December 31 thereafter, also will detail the manner in which incidents of FWA are detected including specific steps taken to combat fraud, waste and abuse and timelines for identifying, acting upon and reporting FWA as outlined above. All changes to the plan will be submitted to MLTC for approval at least 30 days prior to implementation.

Best Practices from Other States

The processes outlined throughout this response are taken from our best practices and lessons learned from across our affiliate health plans. Below are two examples (**Figure 2**) from WellCare's Georgia operation showing two different types of FWA behaviors identified and corrected.

Figure 2

FWA: Investigation of Referral Results in Termination and Repayment
WellCare of Georgia received a referral alleging that a provider was providing tutoring services and billing it as counseling. As part of the investigation, we researched the provider's website, which indicated that the provider offered free tutoring, among several other services. The investigator conducted patient interviews with four members for whom the provider submitted bills. All four stated the provider gave assistance with school work and denied that their children received counseling. The investigators confirmed the allegations through record review. The extrapolated overpayment was $256,959, and we collected $141,946.50. The provider was also terminated from the network.
FWA: Data Mining Identifies Aberrant Billing
Using data mining, WellCare's SIU identified a Georgia physician as billing excessively for balloon sinus dilation. The provider routinely billed the procedure for all three sinus regions. The physician billed these procedures for 35 patients in the past year compared to only six patients for the next highest provider in the claims data. We pulled a statistically valid random sample of medical records. Our review determined that none of the balloon sinuplasty procedures were medically necessary. We had an outside specialist review a sample and the outside specialist concurred that the services were not medically necessary. The identified extrapolated overpayment was $297,665.91, and we collected $170,000. In addition, the provider was placed on a corrective action plan.

SECTION IV.O PROGRAM INTEGRITY

94. Describe how the MCO currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the MCO apply methods in Nebraska? (*Page limit 2 pages)*

PARTNERING WITH STATE AND FEDERAL REGULATORS TO INVESTIGATE AND PROSECUTE FWA

In each state in which we operate a Medicaid Managed Care plan, we have established relationships with both the Medicaid program integrity units and the Medicaid fraud units within the offices of the attorney general to ensure our efforts are done in full alignment and so we can supplement their investigative efforts to stop fraudulent and abusive activities.

Figure 3

BUILDING FWA PARTNERSHIPS ACROSS AGENCIES

WellCare's Experience in Working with Other Entities

	Jan. 1-Dec. 31, 2014	Jan. 1-Oct. 31, 2015
Referrals to State Regulators, including MFCUs, Medicaid Program Integrity units, OIG, etc	666	806
Requests for Information completed and sent to law enforcement and regulatory Agencies	844	1,245

Additionally, we work with other health plans and with federal regulators as needed depending on the scope and severity of the suspected fraud or abuse (**Figure 3**). This can include sharing data from individual cases or collaborating on best practices to mitigate waste in the system. In some affiliates, for example, we meet regularly with the state and other health plans to discuss opportunities to work together and identify waste or abuse in the system and new approaches to addressing FWA.

We find these partnerships crucial because every entity can have complimentary approaches, resources and information that strengthen each of our individual efforts. The forms these relationships take can differ based on different state contractual and reporting requirements, but generally follow similar patterns. The interactions with other states can be broken into a few main areas:

- Formal reporting requirements
- Sharing of records, data and other investigative information
- Regular meetings and opportunities for collaboration
- Formal and informal contacts among investigate staff members

Every state has different reporting requirements and different requirements around MCO interaction with the corresponding state investigative units. Our Georgia affiliate, for example, alerts the Georgia Department of Community Health Office of Inspector General on all cases of suspected fraud or abuse when WellCare determines further action is required. All of our investigative material is forwarded to the Georgia Medicaid Fraud Control Unit upon request.

In addition to individual reporting of suspected F&A, our SIU routinely submits a variety of reports to DCH:

- Fraud and Abuse and Pharmacy Lock-In reports provided to DCH ensure all cases of suspected F&A are reported in a timely manner. These reports include all information required by DCH and communicated through the DCH Requirements Analysis Documents (RADs).
- GA Quarterly FWA Report.
- GA Quarterly Behavioral Health Report.
- GA Department of Insurance (DOI) Reporting.

- Quarterly case status reports to the DCH-OIG office for discussion during joint CMO/DCH OIG/MFCU face-to-face information sharing meetings.
- Reports of all Program Integrity settlement agreements entered into with Providers within seven business days of the settlement.

WellCare's affiliate in Missouri, known as Missouri Care, has developed similar working relationships with their state investigators. There, our SIU follows the state's pre-defined Fraud, Waste, and Abuse Policy in reporting fraud and abuse complaints, investigation findings, and violations to the following entities:

- MO HealthNet Program Integrity Unit
- Missouri Care's Board of Directors, Health Plan Administrator and various committees
- Missouri's Medicaid Fraud Control Unit as appropriate
- Center for Medicare & Medicaid Services (CMS)

Missouri Care also provides a fraud and abuse activity report on a quarterly basis and an annual summary report to MO HealthNet. Additionally, the State Program Integrity team meets with Missouri Care's Compliance and Regulatory staff quarterly to exchange information, collaborate on suspected fraud and abuse activities, and identify opportunities for improving our processes for preventing, reducing, detecting, correcting, and reporting suspected or known fraud and abuse.

Applying WellCare's Methods to Work across Entities to Fight FWA in Nebraska

WellCare looks forward to developing close working relationships with the Nebraska Medicaid Program Integrity (NMPI) staff as well as the Medicaid Fraud and Patient Abuse Unit (MFPAU) within the Nebraska Attorney General's office to fight fraud and abuse in Nebraska's Medicaid program and preserve precious tax dollars for members who need them.

We will take the best practices learned working with state and federal entities for 30 years as noted in the examples above to drive our Nebraska efforts in line with the contractual and regulatory requirements for reporting FWA and recovery of any dollars expended because of fraudulent or abusive behaviors. Some of these efforts include:

- Immediately reporting to NMPI any suspicious or knowledge of fraud
- Sharing all data and information as requested to further an investigation
- Cooperating fully in any investigation or prosecution of FWA activities by any duly authorized government agency
- Provide NMPI and MFPAU unfettered and timely access to or copies of any records maintained by the WellCare or our providers to assist in any investigation or prosecution
- Ensure all of our subcontractors also work collaboratively and cooperatively with any investigation or prosecution of FWA
- Provide MFPAU staff with access to any of our business locations to help further their investigative efforts as needed and upon request
- Ensure MFPAU is aware of any hearings or reviews of our decisions and that MFPAU staff can attend any such hearings

Additionally, we believe a model similar to the one in Missouri where the Nebraska Program Integrity Officer meets regularly with NMPI and MFPAU investigators would be very helpful in further solidifying collaboration and information on shared cases.

SECTION IV.O PROGRAM INTEGRITY

95. Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the MCO apply methods in Nebraska? *(Page limit 3 pages)*

PREVENTING FRAUD, WASTE, ABUSE AND ERRONEOUS PAYMENTS THROUGH MEMBER AND PROVIDER EDUCATION AND EMPOWERMENT

WellCare weaves education about Fraud, Waste and Abuse (FWA) into our initial and ongoing communications with both providers and members because we know that the best line of defense to prevent erroneous payments is to ensure members and providers know how to avoid irregular behaviors, as well as to empower them to detect and report suspicious activity.

This process begins with our employees, who serve on the front lines working with providers and members every day. Every employee of WellCare undergoes extensive compliance training (including specific FWA training) within 30 days of being hired and annually thereafter so they can respond to potential cases of FWA and can pass important information on to providers and members through both formal and informal means. Associates in reimbursement-related functions also receive supplemental FWA specific training, which must be completed within 30 days of hire and annually.

WellCare's Special Investigative Unit (SIU) helps develop and maintain all FWA training. Topics of training include:

- Pharmacy Related Abuse Red Flags Training
  - Does the prescription look altered or possibly forged?
  - Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
  - Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)?
  - Is the prescription appropriate based on beneficiary's other prescriptions?
  - Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?
- Provider Related Abuse Red Flags Training
  - Does the provider write for diverse drugs or primarily only for controlled substances?
  - Is the provider's treatment appropriate for the member's health condition (medically necessary)?
  - Is the provider writing for a higher quantity than medically necessary for the condition?
  - Is the provider performing unnecessary services for the member?
  - Does the provider bill the sponsor for services not provided?

Additional red flags identified through various sources, including the Medicare Parts C and D FWA training developed by the Centers for Medicare & Medicaid Services are also incorporated in WellCare's FWA training. Additional topics covered include:

- State and federal laws and regulations related to FWA
- An associate's affirmative duty to report suspected FWA
- Federal and state laws and the Company's policy prohibiting retaliation against an associate who in good faith reports a compliance or FWA-related concern
- The means of reporting suspected or actual FWA
- Empowering members to avoid and fight fraud, waste and abuse

We have learned through the years of working with Medicaid and Medicare enrollees that some of the best referrals come from members who are often the first ones to become aware of fraudulent, wasteful or abusive behaviors. And, while estimates say that less than 25 percent of health care fraud is committed by members, we also know that members need to be reminded of the importance of not sharing cards or participating in other fraudulent and abusive activities.

Figure 4

To that end, WellCare uses several tools to continue to educate members about FWA – both how to recognize and report FWA, as well as reminders of what constitutes FWA activities by members.

This is done from the very beginning in the member welcome packet, through the member handbook and member website (**Figure 4**). Members also receive ongoing education through member services, community outreach and our newsletters. Our member handbooks and website, describe the definition of fraud, waste, and abuse and gives clear examples and explanations on how this is tracked and monitored by WellCare.

Information shared with members includes:

- An explanation of what constitutes fraud, waste and abuse
- Examples of FWA behaviors to look out for
- Clear instructions for reporting potential FWA including an explanation that there are never repercussions for reporting FWA

Finally, members are involved in FWA detection and prevention through random service verification. WellCare's verification of services reporting consists of contacting a statistically significant sample of members who have received services each quarter. The sample size for each quarter is about 600 members, and generally reflects a mix service types. All findings made through service verification will be reported to the Nebraska Medicaid Program Integrity (NMPI) quarterly.

Educating Providers on their Responsibilities Regarding Fraud and Abuse

Our provider services personnel, provider manual, and website educate providers on WellCare's FWA Plan including providers' respective responsibilities, the responsibilities of others, the definition of fraud and abuse, and how and where to report suspected or known fraud and abuse.

Within 30 days of contracting with a provider, WellCare's Provider Services personnel schedule an orientation with each contracted provider to review contract requirements. This orientation includes an overview of FWA and specific examples of provider fraud, such as upcoding, billing for services not

provided, and submitting false encounter data. Ongoing communications with providers include information on appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers. WellCare network providers can view or download the most up-to-date version of the Provider Manual and information on how to locate regular fraud and abuse updates on our website. Some examples of content include:

- Details around WellCare's commitment to compliance including HIPAA requirements
- Standard Code of Conduct for providers in preventing, identifying, and reporting compliance violations
- Prevention, identification, and reporting of known or suspected fraud and abuse including the availability of the following:
  - Corrective action guidelines
  - Deficit Reduction Act of 2005 and Federal False Claim Act provisions
  - Confidentiality and non-retaliation protections

Periodic articles on fraud and abuse are published in monthly provider newsletters, providing additional examples of behaviors to watch for and emphasizing the responsibility of providers in preventing, detecting, and reporting potential suspected and known fraud and abuse.

Additionally, our local Medical Directors, as well as our Clinical HEDIS Practice Advisors (CHPAs) play a key and continuous role in ongoing training and education of providers about wasteful and abusive practices. Armed with data from an array of sources, our clinical and medical teams sit down with providers to discuss Clinical Practice Guidelines when utilization patterns and clinical quality data shows outlier aberrations from those guidelines. We also educate on medical necessity criteria to help ensure appropriate use of health care resources.

Under our hybrid pharmacy program, integrated and in-house pharmacy staff use data from Drug Utilization Review and such programs as Lock-In to meet with high volume providers to discuss appropriate, evidence-based and guideline driven prescribing practices to, not only prevent waste or abuse, but drive improved member outcomes.

Deploying WellCare's Robust FWA Educational Efforts in Nebraska

Our Nebraska-based Program Integrity Office and dedicated investigative staff will partner across functional areas, including member and provider services as well as with our WellCare training and SIU staffs to ensure both the content and distribution of FWA training materials meet the unique needs of Nebraska members and providers.

We will use traditional models of education and outreach as outlined above within Nebraska, and partner with NMPI to distribute tailored messages as requested as well. We will also use Nebraska-specific results from data mining efforts where there are identified trends of concern to shape educational messages distributed any of the following methods:

- New member and provider orientation
- Member and provider newsletters or alerts
- Website updates
- Member and provider mailings
- Providing standard information in each of our Nebraska Welcome Rooms, offices and at community events

SECTION IV.O PROGRAM INTEGRITY

96. Describe the MCO's method and process for capturing TPL and payment information from its claims system. Explain how the MCO will use this information.

(Page limit 3 pages)

ANOTHER LINE OF DEFENSE: WELLCARE'S METHOD AND PROCESS FOR CAPTURING TPL

Properly coordinating benefits and Third-Party Liability (TPL) is a critical step in ensuring there are no erroneous, wasteful and duplicate payments. WellCare recognizes that Medicaid is the "payer of last resort" and has built detailed processes for ensuring TPL payment information is captured and used appropriately.

The coordination of benefits (COB) process, also known as cost avoidance process, begins by adding other health insurance coverage information to the member's record in the WellCare claims system. The other coverage details include: carrier name, policy number, group number, subscriber name, subscriber identification number, effective dates and termination dates.

The other health insurance information is collected through a variety of sources including State eligibility files (834 HIPAA transactions), State TPL files, provider claims with an explanation of payment (EOP) attachment, the member himself/herself as part of initial enrollment activities and as a routine follow-up question during member telephone contacts.

TPL and Cost Avoidance at Work

In one of our affiliate programs, WellCare of Kentucky, the following amounts were avoided and recovered through proper application of TPL Avoidance Processes.

- Inpatient: $26,547,428
- Professional: $15,242,571
- Pharmacy: $1,133,034

Total: $42, 923,033

Added to the amount of $1,919,098 identified through recovery pursuit, **WellCare of Kentucky saw a total of $44,832,141 in cost avoidance and recovery in one year.**

WellCare systematically uploads Medicare coverage details from State 834 files to the member's COB History tables in the WellCare Claim System without additional validation. All other sources of COB information mentioned above are validated via 270 transaction or outbound phone call to the other insurance carrier.

WellCare also takes a proactive approach to identifying other sources of primary insurance coverage utilizing a set of vendors who specialize in TPL identification. These vendors hold data share agreements with commercial insurers to identify Medicaid members with medical and/or pharmacy coverage. WellCare sends weekly or monthly HIPAA-compliant claims and eligibility data feeds to the TPL identification vendors to evaluate and determine if any members have other coverage through a commercial source. The vendors return a data feed containing other insurance information in a date-sensitive and HIPAA-compliant format which is used to update the members' COB History tables in the WellCare Claim System.

Additionally, WellCare uses a vendor to identify claims with accident-related diagnoses (e.g., sprains, fractures and head and back injuries) that represent potential worker's compensation benefit cases or other subrogation opportunities. The vendor also attempts to identify treatment for incidents such as car accidents, injuries on someone else's property, work-related injuries, animal bites and other accidents.

WellCare sends monthly medical and pharmacy claims and eligibility data feeds to the subrogation vendor for members in all of WellCare's programs. WellCare also sends referrals involving paid claims

when they believe the member may have been involved in an accident. The vendor investigates all referrals and all potential cases that have more than $250 in paid claims by sending a State-approved letter and questionnaire to WellCare members.

Avoiding Future Claim Payment

If other primary insurance information is loaded in the WellCare Claim System for a member, then newly received claims will be systematically held for manual review.

If the date of service on the claim falls within the coverage period of the other primary insurance policy and no primary EOP is attached, a Remittance Advice will be sent to the provider along with a corresponding Other Insurance Information letter that advises the provider that other primary insurance exists and should be billed first. The Other Insurance Information letter contains the necessary other insurance information required (i.e., carrier name, carrier address, policy number, group number, subscriber name) for the provider to submit the claim for payment.

If the date of service on the claims falls within the coverage period of the other primary insurance policy and a primary EOP was attached, the claim will be processed by the WellCare claim processors by considering the primary payment and paying the remaining coinsurance, deductibles, etc.

Cost Avoidance Exceptions—Pay and Chase Activities

WellCare will process claims in accordance with any and all cost avoidance exceptions. If a cost avoidance exception exists on a claim or if other primary insurance information is loaded into the claim system after claim payment, then previously paid claims will be reviewed systematically for overpayments. WellCare identifies overpayments in a weekly script to ensure that providers are notified in a timely fashion.

Post-Payment Recovery

WellCare uses two methods for recouping erroneous overpaid claims: Direct Provider Recovery and Carrier Billing.

Direct Provider Recovery

If the enrollee's state allows for direct provider recovery, then identified overpaid medical claim(s) that have a date of service within the last 10 months will be marked for internal recovery efforts. Internal recovery efforts begin with a letter to the provider advising them that a primary insurer was responsible for the claim payment and that a refund or recoupment (where contractually allowed) is necessary to satisfy the overpayment. The letter will provide the necessary other insurance information required for the provider to re-bill the claim to the primary insurer.

Carrier Billing

WellCare utilizes an outside vendor to submit bills to health insurance carriers when commercial, Medicare Advantage or Tricare coverage is primary to WellCare. This method is used if an identified overpaid claim falls into one of these categories:

- The enrollee's state does not allow for direct provider recovery
- Claim was paid due to cost avoidance exception rule
- The date of service on the claim is greater than 10 months from overpayment identification date
- The paid amount on the claim is lower than the internal recovery effort threshold

The recovery vendor receives monthly HIPAA-compliant claim data feeds to evaluate for overpayment recovery. Recoveries from primary carriers are refunded to WellCare on a monthly basis and posted to the enrollee's claim history.

Identified overpayments are tracked in a Recovery Database for reporting and collection. Overpayments

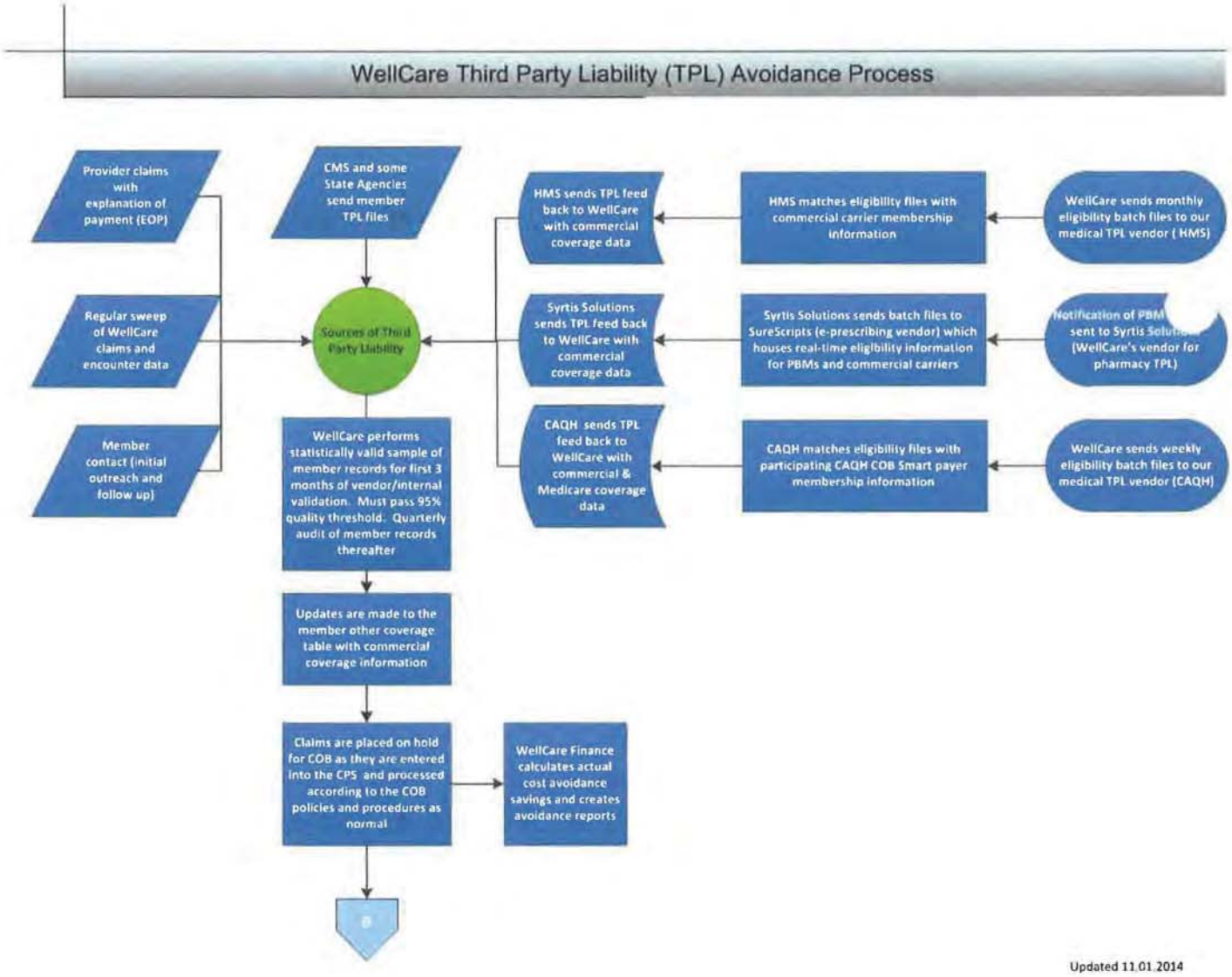
recoveries are applied to the member's claim history in WellCare's Claim Processing System and will flow through to Encounter Data.

MAINTAINING TPL DATA AND REPORTING TPL DATA TO STATE

WellCare maintains a robust database of TPL information directly within the Claims Processing System outlined in (**Figure 5**). Valid TPL coverages are updated on the members' eligibility records in the Claims Processing System, making them accessible for claims processing and viewable by Care Management and Customer Service staff. Providers and Members can contact the Customer Service department to provide new TPL information or to request an update to existing TPL information.

WellCare will generate TPL avoidance and collections reports in any format and timeframe designated by the state of Nebraska.

Figure 5



SECTION IV.Q PROVIDER REIMBURSEMENT

97. Provide a detailed description of the MCO's approach to implementing a value-based purchasing model with providers. Include at a minimum the MCO's:

- Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets
- Approach to identifying initiatives and performance measures on which to focus, proposed engagement strategies to encourage provider participation, incentives the MCO will use, and methodology and timing for determining if providers have met requirements
- Plan for entering into value-based purchasing agreements with 30% of its provider network by December 31, 2019.
- Discussion of best practices and lessons learned.

(Page limit 6 pages)

PHILOSOPHY REGARDING VALUE-BASED PURCHASING AND RISK-SHARING AGREEMENTS AND EVIDENCE OF EFFECTIVE USE

WellCare views value-based purchasing (VBP) and risk-sharing agreements as an important part of our quality strategy to improve health outcomes and quality of care while reducing the rate of costly and avoidable care. Our approach to value-based purchasing and risk-sharing arrangements includes the following key principles:

- Alignment with our quality program and clinical outcome goals
- Targeting of both broad range of clinical performance measures and provider types to ensure that a broad cross section of members are impacted
- Achievement of quality measures before financial efficiency incentives are earned because financial efficiency alone does not promote our quality strategy
- Creation of sustainable, successful partnerships by ensuring that these payment arrangements and incentives are tailored to each group

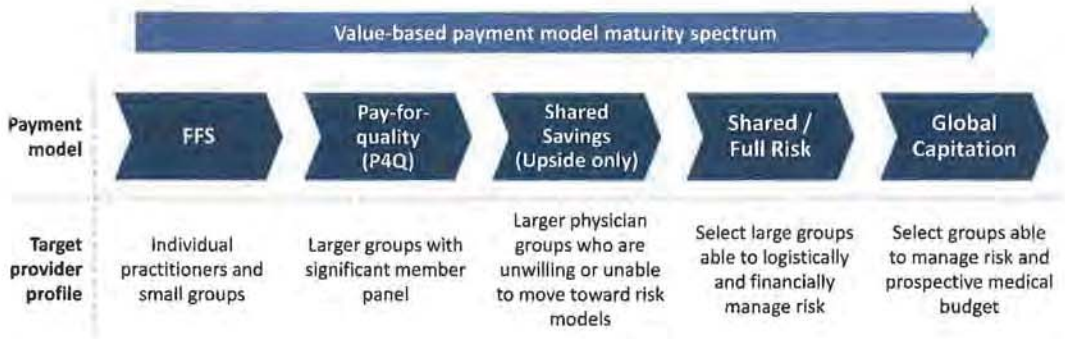
Meeting Providers Where They Are: WellCare's Value-based Payment Continuum

Our value-based purchasing programs drive quality, cost-efficiency and member outcomes. As such, they are a strategic component of our network development and provider services functions. Our field-based provider services representatives, medical director and network leadership work closely with our network providers to assess their level of maturity, target providers based on willingness and capacity, and identify those providers who are ready to move to the next stage in advanced value-based reimbursement relationships.

As shown in **Figure 1** (on the next page), WellCare views value-based payments as a continuum. From basic fee-for-service (FFS) or capitation with quality bonuses, to shared savings, to full risk models, to global capitation, we are prepared to work with providers regardless of where they sit on the payment continuum. As you move from left to right there is an expectation that providers are more experienced and comfortable with value-based payment designs including more complex arrangements which introduce financial risk.

Nebraska represents a perfect example of this continuum in motion with providers at every level, including some larger providers who are beginning to take on risk-based arrangements, and several in the middle with opportunities to benefit from shared savings or upside-only bonus payments for closing care gaps and improving health outcomes. Payer and provider partnerships on the commercial health plan side in various segments of the state have paved the way for innovative VBP solutions from Medicaid plans.

Figure 1



To facilitate provider migration along the value based payment continuum and enhance each provider's chance for success in the program, we offer tools such as:

- Data analytics and information sharing supports including quality dashboards with HEDIS scores, care gap reports, and quality trends
- Information technology infrastructure such as assistance with health information exchange connectivity and electronic health record support
- Clinical practice support and training through our clinical HEDIS practice advisors (CHPAs), medical director, pharmacy director, behavioral health managers, care managers, and disease managers, among others
- Incremental payment bonuses to non-PCMH practices with a minimum panel size who adopt electronic health records (EHRs)
- Medical director and network leadership meetings with providers interested in full risk and global capitation as well as a formal assessment to determine the provider's capacity to assume risk. Assessment includes review of provider operations and infrastructure, size of the membership pool, and historical claims data to ensure that the size and risk burden of the patient population is considered in the funding arrangement

Evidence of Effective Use

Our effective use of value-based purchasing is demonstrated by the fact that more than half of our Medicaid members are currently impacted by value-based purchasing quality incentive programs. For 2014 performance, we distributed $10 million of quality bonus payments to nearly 400 Medicaid provider groups, averaging $25,000 per group. For 2015 performance, we expect to distribute approximately $11 million of quality bonus payments to our Medicaid provider network.

We constantly expand our value-based purchasing offerings based on the needs of our members and the priorities of our state partners. For example, in Missouri, where behavioral health integration is a critical priority for our state partners, we have started offering community mental health centers (CMCHs) incentive payments for high standards of performance on follow-up after hospitalization rates.

WellCare continually evaluates our value-based purchasing arrangements for effectiveness and alignment with quality measures. As an example, we recently restructured a provider contract with a large group serving approximately 20,000 of our Medicaid members to align incentives around improved health outcomes. This organization has been an important partner for many years and, while performing well from an efficiency standpoint under our gain sharing program, was not meeting our expectations on the quality front. We restructured the arrangement to include minimum quality standards that must be met in order for the group to realize any efficiency surplus. We also included bonus provisions for the achievement of high levels of quality performance for their assigned members.

Additionally, our partnership with Children's Mercy Pediatric Care Network (CMPCN) in Missouri provides another example of effective use. Under this risk-based agreement, covering approximately 25,000 Medicaid members, CMPCN is paid a percentage of member premiums to provide comprehensive medical management functions for our members, including utilization management, care management and disease management. We maintain oversight of the program and meet regularly with CMPCN leadership and providers to discuss performance and areas for improvement.

Another example of successful collaboration through a VBP arrangement is with The Children's Care Network, Inc. in Georgia. Our collaboration with this physician-led, subsidiary corporation of Children's Healthcare of Atlanta, is an example of where we are using value-based purchasing to align incentives to drive quality and efficiency of care achievements to improve health outcomes for Medicaid children in Georgia. The Children's Care Network, Georgia's only clinically integrated pediatric network, is managing care for approximately 77,500 WellCare Medicaid members. Under the agreement, WellCare provides incentive payments to The Children's Care Network for quality-based improvements in certain Healthcare Effectiveness Data and Information Set (HEDIS) measures related to important dimensions of care and service.

The Children's Care Network

Identifying Initiatives, Proposed Engagement Strategy, Incentives, Methodology and Timing

In identifying performance measure and initiatives used in VBP arrangements, we look at:

- Performance measures established by state partners
- Population health priorities for the members we serve
- Data analytics that identify prevalent conditions, areas of greatest need, and areas of potential impact

Starting with these measures ensures a common definition of success between WellCare, our providers, and our state partners. We have found that 10 to 12 performance measures delivers an effective value-based purchasing program so we prioritize the measures used to ensure we focus on those areas with the greatest need and opportunity for improvement.

We then identify the specific provider types that are best positioned to impact these measures, and design programs to reward strong performance and improvement. Thus far, our primary areas of focus have been preventive care and the management of chronic conditions. While we offer many different programs across our Medicaid markets, most can be categorized into two core frameworks:

- **Pay for Quality (P4Q):** Offers PCPs a per member per month (PMPM) bonus for achieving specified quality of care targets which are usually based on HEDIS measures. These bonus opportunities are generally offered to the largest primary care practices representing at least 50 percent of the membership in a given market or having at least 500 WellCare Medicaid members.
- **Gain / Risk Sharing with Quality Standards:** Larger provider organizations, including PCP groups and health systems, who meet the criteria and display a willingness to participant in shared savings, are offered the opportunity to earn a portion of the savings achieved when they meet specified quality and cost efficiency performance targets.

In addition to the programs described above, WellCare will also incorporate the following, more specialized components into our Heritage Health program value-based purchasing strategy.

- **Behavioral Health Homes:** We will establish behavioral health homes with qualified CMHCs, federally qualified health centers (FQHCs), and other behavioral health and substance use providers who are able to deliver integrated services and adhere to the principles of a behavioral health home. Behavioral health providers will be offered a contractual PMPM fee to fund physical and behavioral health care coordination activities for qualified members. Performance bonuses will be included for

the achievement of specified clinical outcome targets.

- **Obstetrician / Healthy Pregnancy Incentive:** We will offer an obstetrician enhanced payment similar to that piloted in our South Carolina affiliate. Obstetricians have the ability to earn an enhanced payment per delivery (that matches the prevailing commercial rate in the market) based on the satisfaction of specific criteria including prenatal care, postpartum visits, evidence of a pre-delivery pertussis vaccination, and completion of a screening tool by the end of the second trimester.
- **Specialists:** We will offer value-based purchasing programs tied to quality measures to select identified specialists based on their role in managing impactable conditions for members with complex needs.
- **Hospitals and Health Systems:** We will partner with select hospitals and integrated health systems, including the establishment of accountable care organization (ACO) models, such as the partnership we have in place in Missouri with CMPCN. Several organizations we met with, including Children's Hospital in Omaha, expressed interest when we met with them in a VBO arrangement for Heritage Health members and, we are eager to work with Nebraska providers to find the right individualized solutions to drive improved health outcomes.

Participation and Engagement Strategies

Our strategies to encourage participation and engagement in our VBP programs are led by direct dialogue between providers and our local team. Provider organizations are educated about our value-based programs through the combined efforts of our medical director, network leadership, provider services representatives, and practice advisors as part of our initial and ongoing network development activities. In addition to broad based communication such as mailings, our provider handbook, website and newsletters, we engage directly with providers through on-site visits, statewide regional information summits, statewide orientation sessions, provider forums and targeted education.

To increase participation and engagement we focus on the following strategies:

- **Provider Understanding of the Program:** Broad based education activities using all available avenues to help provider groups understand how the program works and how they are being evaluated and rewarded.
- **Keep it Simple:** Our value-based programs use targets that are easy to understand and to measure. We have found that when programs are too mathematically complicated, providers lose interest in participating or participate in a less than optimal manner.
- **Realistic Chance of Success:** Provider groups must believe they have a realistic change of receiving a reward. While we typically aspire to strictly reward the highest levels of performance, we have found that for certain groups in certain markets (particularly rural or frontier), this is not a current reality. Our programs focus on both absolute performance and improvement to ensure all providers have a meaningful motivator.
- **WellCare Support:** Providers want to know that their success is not based on solely on their individual efforts, but that WellCare is contributing resources and programs to help them be successful. Key areas of WellCare support for these programs include:
  - Member outreach programs, including appointment scheduling assistance
  - Data, reporting and analytics including status reports so providers know how they are doing under the incentive program and areas to focus on
  - CommUnity Advocacy program designed to connect members with key social services to help meet socioeconomic needs that can be as important as clinical barriers to care

We view our CommUnity Advocacy program as a unique differentiator for WellCare and our value-based purchasing programs. WellCare's ability to connect members to community support structures for things such as bill payments, transportation, housing assistance, and snow removal, can often make the difference for a member receiving a needed service or properly managing a chronic condition.

Incentives

As described above, our incentives will vary based on the specific provider and the membership they serve. Our value-based purchasing incentives will be informed by the Request for Proposal (RFP) Attachment 7 – Performance Measures as well as our own data analytics. Some of the key measures we anticipate targeting are shown in **Figure 2**, by provider type.

Figure 2

Provider Type	Sample Incentives
PCPs	➢ Childhood immunizations ➢ Well-child visit in first 15 months of life ➢ Immunizations for adolescents ➢ Developmental screening in the first 3 years of life ➢ Well-child visits in the 3rd through 6th years of life ➢ Adolescent well-care visit ➢ Cervical cancer screening ➢ Chlamydia screening in women ➢ Flu vaccinations for adults age 18 and older ➢ Screening for clinical depression and follow-up plan ➢ Adult body mass index assessment ➢ Medical assistance with smoking and tobacco use cessation
Behavioral Health Home	➢ Follow-up after hospitalization for mental illness ➢ Adherence to antipsychotics for individuals with schizophrenia
Obstetricians	➢ 6 or more prenatal visits before delivery ➢ Postpartum visit within 6 weeks of delivery ➢ Evidence of pre-delivery pertussis vaccination ➢ Completion of required screening tool by end of the second trimester
Specialists	➢ Use of spirometry testing in assessment and diagnosis of COPD ➢ Pharmacology management of COPD exacerbation
Hospitals and Health Systems	➢ All-cause readmissions ➢ Timely transmission of transition record

Methodologies and Timing

Our methodologies for determining whether providers have met value-based purchasing program requirements are clearly spelled out in a set of program documents which include:

- What is being measured
- How is it being measured
- What the targets are
- When bonuses are paid

Our value-based purchasing policies and procedures ensure each of these considerations is thoroughly addressed, including any required review and approval by our state partners. Most of our quality-based incentive programs use HEDIS and other performance metrics and include such components as:

- Defined set of performance measures with specific performance targets based on NCQA national Medicaid percentiles
- Evaluation of provider-level results versus the performance targets at the end of the performance period with bonus payments to providers meeting or exceeding performance targets
- Bonuses on a measure-specific basis – typically expressed as a defined dollar amount multiplied by the total number of HEDIS compliant members for that measure
- Average NCQA percentile approach that computes an NCQA performance percentile for each

measure (e.g. 50th, 75th), and then averages those across all 10 – 12 performance measures
- Absolute threshold for receiving a bonus such as average percentile at or above 60th, as appropriate
- Rewards for improvement over prior year results such as 30th percentile improving to 40th

Plan for Entering into VBP Agreements with 30 Percent of Network

To achieve this MLTC's standard of 30 percent of the network in VBP arrangements by December 31, 2019, we will use the following contracting mechanisms:

- **PCP Pay for Quality:** PMPM bonus to those PCPs who achieve quality of care targets tied to MLTC population health priorities such as HEDIS measures
- **Gain/Risk Sharing:** Gain/risk sharing based on cost efficiency and quality performance targets for large provider organizations, including PCP groups and health systems
- **Behavioral Health Homes:** PMPM fee to fund integrated care coordination and performance bonuses for clinical outcome targets for qualified CMHCs, FQHCs, and other behavioral and substance use providers
- **Obstetricians:** Enhanced payment per delivery when established quality standards are met including prenatal visits, screening, postpartum care, and pertussis vaccination
- **Specialists:** Value-based purchasing programs tied to quality measures for identified specialists, such as cardiologists
- **Hospitals and Health Systems:** Partnerships with select hospitals and integrated health systems, including the establishment of ACO models.

Discussion of Best Practices and Lesson's Learned

Our extensive experience in designing and executing value-based purchasing programs informs our perspective on best practices and lessons learned as shown in **Figure 3**.

Figure 3

Lessons Learned	Best Practices
Practices in rural, frontier, or inner city areas often lack resources and technology infrastructure and are frustrated by unachievable goals.	**Ensure Success is Achievable:** Incorporate rewards for improvement into program design, even if from a low starting point.
Providers will not engage in programs that are too mathematically complex or too difficult to understand.	**Keep it Simple:** Target performance measures that are easy to understand and measure.
If providers do not understand what is being rewarded or how they are evaluated, they have a low chance of success.	**Educate, Educate**: Communicate details of value-based program consistently and comprehensively to providers through all provider facing associates
Practices must invest resources to be successful under value-based programs with incentive payments the return on investment. Predictable programs help them make decisions to implement the infrastructure required for success.	**Make it Predictable:** Thoughtfully design improvements to minimize year-over-year changes.
Not all value-based programs are suitable for each provider practice. Pushing a practice into a reimbursement structure that is not right for them is not sustainable in the long-run.	**Meet the Provider Where They Are:** Meet the provider where they are on the continuum of value-based arrangements.
Value-based programs focused on cost efficiency only do not support quality outcomes.	**Always Include Quality Standards:** Incorporate minimum quality standards below which surpluses are not distributed and upside multipliers for strong quality performance.

SECTION IV.Q PROVIDER REIMBURSEMENT

98. Provide a description of the MCO's proposed MAC program, including methods for setting MAC prices, criteria used to select covered MAC drugs, process for resolving disputes regarding the MAC value, how the MCO will evaluate its MAC program, and any other program components the MCO considers important for achieving the State's NMMCP goals. Describe the MCO's experience with establishing MAC programs in other states, and highlight strengths and challenges. *(Page limit 6 pages)*

DESCRIPTION OF OUR MAC PROGRAM: A FOCUS ON FAIRNESS AND ACCURACY

Our maximum allowable charge (MAC) program is administered by our pharmacy benefit manager (PBM), CVS Caremark. This generic pricing program combines broad coverage with competitive rates for generic products and promotes generic utilization. Generic products represented on the MAC drug list for our generic pricing program are established at a generic class level to set a consistent price regardless of manufacturer. CVS Caremark accomplishes this by continually surveying the market for price changes, performing timely and regular updates to the generic pricing program, and validating product availability through pharmacy and wholesaler communications. This generic pricing program is monitored based on utilization, and prices will be adjusted to meet MLTC requirements. Our PBM maintains a proprietary MAC list as a standard offering of MAC drugs applicable to the Heritage Health plan.

Our PBM program supports transparency and fairness to pharmacies while at the same time promoting the appropriate use of the right drug at the right time. In an effort to better service our pharmacy network partners, network pharmacies have access to MAC pricing through our PBM's secure portal. ***MAC pricing is reviewed and updated to their website weekly.***

METHODS FOR SETTING MAC PRICES

Our PBM will use an analytical process to establish a Heritage Health MAC for generics and multi-source brand products. The analytical process involves a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by our PBM and MAC pricing information provided by retail pharmacies as part of payment disputes. MAC prices are subject to change weekly based on marketplace trends and dynamics. New bioequivalent generic products will be added to the MAC list for our generic pricing program not more than 30 days after they are readily available from more than two generic vendors.

Our PBM regularly updates the prescription drug pricing standard it uses to reimburse network pharmacies based on the cost of the drug. These updates occur on January 1 of each contract year and weekly thereafter. Our PBM ensures that its contracts and written arrangements with pharmacies or other provider include provisions for regularly updating the prescription drug pricing standard used to reimburse network pharmacies as applicable. The pricing standard and frequency of updates is also posted in the PBMs provider handbook. Pharmacy contracts also indicate the source used for making such pricing updates.

Network pharmacies access MAC pricing through our PBM's secure portal. MAC pricing is reviewed and updated to their website weekly and pharmacies may go to the website at any time to obtain MAC pricing. Our PBM and pharmacy contracts address regular pricing updates. Our internal processes ensure that fee schedules tied to any drug pricing standard are updated within these prescribed timeframes, and that all claims are adjudicated in accordance with appropriately updated fee schedules.

We eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace. MAC pricing is reviewed and updated based on market changes a minimum of weekly for both price increases and decreases.

There is typically one unit MAC price across all package sizes and national drug codes (NDCs) for each generic product. However, there may be some instances where a generic product may have multiple MAC prices if pricing is established at a package size or NDC level. The industry-wide NCPDP D.0 standard for multi-ingredient compounds is required for compound claims, and we support this functionality. This functionality will provide for determining an allowable ingredient cost for each NDC using lesser of logic—comparing the average wholesale price (AWP) discount, MAC (if applicable), and the submitted ingredient cost for each individual component in the recipe. We demonstrate savings from the MAC pricing in our generic pricing program by comparing the MAC to the AWP or the usual and customary price submitted by the pharmacy.

CRITERIA USED TO SELECT COVERED MAC DRUGS

WellCare will follow the Nebraska Medicaid preferred drug list (PDL). Any changes to the PDL will be determined by the Nebraska Pharmacy and Therapeutics committee and implemented by WellCare. Medi-Span will provide the criteria for MAC list/rates.

WellCare will provide a MAC file to the MLTC PDL contractor a minimum of quarterly, or as requested by MLTC, in the file format defined by MLTC. MAC pricing will not apply to the name-branded product, if the name-branded product was approved to be dispensed as medically necessary. This will require a drug evaluation review or prior authorization. We will also develop a Nebraska specific policy and procedure that meets state and federal requirements for providing brand-name products when the prescriber appropriately determines and documents that the brand-name product is medically necessary.

To determine whether a product is eligible for a MAC price in our generic pricing program, we consider several factors including bioequivalence, number of vendors in the marketplace, and availability of the product. Claims volume is also taken into consideration.

The vast majority of drugs on the MAC list applicable to the Heritage Health plan are A-rated with the exception of a few unrated generics. New A-rated generic drugs will be added to the MAC list for the PBM generic pricing program applicable to the Heritage Health plan not more than 30 days after the date on which they are readily available from more than two vendors.

Products that do not meet our MAC criteria may be excluded from the MAC list applicable to the Heritage Health plan. This may include generics with exclusivity or limited availability, non A-rated products, and low claim volume generics.

PROCESS FOR RESOLVING DISPUTES REGARDING THE MAC VALUE

CVS Caremark has an established process to ensure that MAC pricing is appropriate and not routinely below the wholesale price available to state pharmacists. Their administrative appeals process allows a dispensing provider to contest a listed MAC rate, which includes the following:

- Responding to the provider within seven calendar days
- Taking steps to determine if the MAC price is appropriate given the current state market condition
- When updates are warranted, retroactive changes to the date of service with adjustments effective for all pharmacy providers in the network

Submission of a paid claim by the pharmacy is required for this process. The provider must notify the PBM within the period required by applicable law and provide the following information: date of fill, prescription number, NDC number, drug strength, dosage form, member ID number, and pharmacy NCPDP and NPI number.

Chain and affiliation (PSAO) pharmacies submit MAC paid claim appeals through their respective chain or PSAO headquarters, which then submits appropriate data to the PBM. Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) submit MAC paid claim appeals through

the pharmacy help desk at 1-800-364-6331.

The review process includes a verification of pricing and product availability through sources of information such as wholesalers, manufacturers, retail pharmacies and Medi-Span. Adjustments are made if appropriate and feedback is provided back to the pharmacy. Evaluation is made to determine the pricing has been appropriately defined and is not routinely below acquisition cost.

HOW WELLCARE WILL EVALUATE ITS MAC PROGRAM

The MAC list and associated pricing for the Heritage Health plan is reviewed continuously and updates made as often as weekly based on marketplace trends and dynamics and MLTC requirements. Our PBM monitors the MAC list for appropriateness by continually surveying the marketplace for price changes and performing timely and regular updates to the MAC list. Supply issues are validated through information obtained from wholesalers, manufacturers, retail pharmacies, and Medi-Span.

WellCare receives a monthly MAC list from our PBM that includes evidence of all changes occurring from the prior month, including additions, deletions and adjustments. There is also data supplied relating to MAC changes resulting from MAC appeals. These files are reviewed by our pharmacy analytics and management ream. This team evaluates the claim performance to ensure the generic effective rate and to validate pharmacy generic reimbursement rates are aligned to expected performance. Any outliers in this review are addressed through the PBM account management team. This review takes place monthly.

WellCare performs an onsite audit at the PBM on an annual basis to monitor the PBM's performance and ensure contracted services are performed in compliance with WellCare's policies, state and federal regulations. The focus of the audit is on claim adjudication to ensure pharmacy claims are paid at the appropriate MAC unit price reported to us from the PBM as well as pharmacy network management.

The PBM must provide all WellCare-requested policies and procedures, as well as all relevant processes, workflows, examples, explanations, contracting logs any other supporting documentation regarding the following audit elements:

- Drug Utilization Review
- Transition
- Claims Data
  - Coordination of Benefits
  - Timely Pharmacy Payments
  - Disputed Claims
  - Overpayments and Underpayments
  - Claim reversals
  - Record Maintenance
  - HIPAA Compliance
  - Catastrophic Recovery
  - Claims Payment Report
- Claim Adjudication System
- Provider Relations
  - Pharmacy Access Standards
  - NCPDP File Updates
  - Pharmacy Contracting
  - Monitoring OIG Exclusion List
  - Fraud Waste and Abuse (FWA)
  - Third Party Pharmacy Audits

WellCare also conducts weekly auditing and validation of the PBM invoices to ensure that charges

accurately correspond to pharmacy member utilization.

OTHER PROGRAM COMPONENTS IMPORTANT FOR ACHIEVING STATE'S NMMCP GOALS

Generally, unit MAC prices are uniform across all package sizes and NDCs for each MAC product. Therefore, repackaging NDCs with manipulated AWP's would be subject to the same MAC pricing logic as any other NDC within the generic drug class.

Our MAC list is typically managed based upon generic product identifier level classifications. There are some instances where MAC pricing is assigned at a package size or NDC level.

MAC reimbursement is communicated to the network pharmacies through the daily online adjudication process and through the secure provider portal. All network pharmacies can submit any MAC inquiries directly to our PBM for research and follow up.

MCO EXPERIENCE ESTABLISHING MAC PROGRAMS IN OTHER STATES

WellCare has extensive experience serving the pharmacy needs of Medicaid members across eight states. Additionally, WellCare has developed a full complement of expertise in three major areas of government-sponsored health care; Medicaid, Medicare Advantage and Medicare Prescription Part D plans.

CVS Caremark is an industry leader that currently serves more than 2,000 clients who provide benefits for 71 million individuals across commercial, Medicaid, and Medicare lines of business. As a leader in the PBM market, they employ a team of industry experts knowledgeable in both the generic manufacturing and retail pharmacy industries to provide competitive generic pricing while encouraging generic utilization. The use of MAC prices in the CVS Caremark PBM's generic pricing program was introduced in 1988.

Strengths and Challenges

WellCare's pharmacy operation is a unique hybrid model with a number of critical functions performed in-house by WellCare personnel coupled with the activities of a PBM performed by CVS Caremark. Under our hybrid model, our corporate pharmacy resources are responsible for prior authorization determinations, appeals, PDL development and management, claims testing, Pharmacy and Therapeutics Committee, quality improvement, retrospective drug utilization reviews, rebate management, and member and provider communications. Our PBM partner processes the pharmacy claims point-of-sale, contracts and remits the pharmacy network, performs phone, desk, and on-site audits, coordinates transition of care, answers after-hours provider calls and provides explanations of benefits.

SECTION IV.Q PROVIDER REIMBURSEMENT

99. Describe the MCO's approach to ensuring that out-of-network prior authorization and payment issues are resolved expeditiously in instances when the MCO is unable to provide necessary services to a member within its network. *(Page limit 2 pages)*

ENSURING RESOLUTION OF OUT-OF-NETWORK PRIOR AUTHORIZATION AND PAYMENT ISSUES

WellCare's goal is a robust, comprehensive and expansive statewide provider network to serve the health care needs of our Heritage Health members. We will consistently monitor and augment our provider network to deliver the highest level of care and service to our members. In circumstances when we do not have a participating provider accessible to a member, we coordinate care for medically necessary covered services through an out-of-network provider to ensure adequate and timely coverage. No prior authorization is required for emergency services. Covered emergency and post-stabilization services performed by out-of-network providers will be reimbursed at 100 percent of the Medicaid rate in effect on the date of service.

For non-emergency services, our process includes:

- Verifying the service is not available in network
- Verifying the provider has no sanctions and is not on the HHS Office of Inspector General Cumulative Sanctions Report
- Initiating a prior authorization in our core processing system
- Establishing a single case agreement with the out-of-network provider
- Assisting with member transportation issues

Coordination of Care

To maintain continuity of a member's care, the member's PCP coordinates referrals for out-of-network specialty care. Often a referring provider reaches out to his or her assigned provider services representative for assistance in obtaining referrals to out-of-network specialists if a member's need for treatment cannot be met through a contracted provider. The representative attempts communication with the out-of-network provider if a relationship is not already established, and coordinates with our utilization management and member outreach or case management teams, as needed, to ensure that the member is involved in the medical decision-making process. If the out-of-network provider agrees to see the member, our utilization management team enters an authorization for service and a network development representative initiates a single case agreement (SCA) to ensure proper payment. The process includes assurance the out-of-network provider is loaded correctly along with the necessary procedure codes to ensure timely payment.

By the Numbers: Rapid Response

95% of Single Case Agreements are completed within 72 hours of the request

Timeliness

Our network management department completes 95 percent of SCAs within 72 hours of the request. If the SCA is of an urgent nature, we complete it the same day. We request claims and encounter data for all out-of-network services and process them in accordance with the same standards as in network claims and encounters. In 2015, we processed 96.75 percent of all clean claims within 14 calendar days of receipt.

Coordination of Payment

In establishing an SCA, our network management department will negotiate payment to the provider in a financially responsible manner that is consistent with MLTC guidelines to ensure delivery of care to the

member. During the first 90 calendar days of program start, payment will be at 100 percent of the Medicaid fee-for-service rate to support continuity of care.

As part of the negotiation process, out-of-network providers agree to a payment arrangement that ensures that the cost to the member is no greater than it would be if the covered service was furnished by a provider contracted within our network. This agreement makes clear that out-of-network providers cannot balance bill a member.

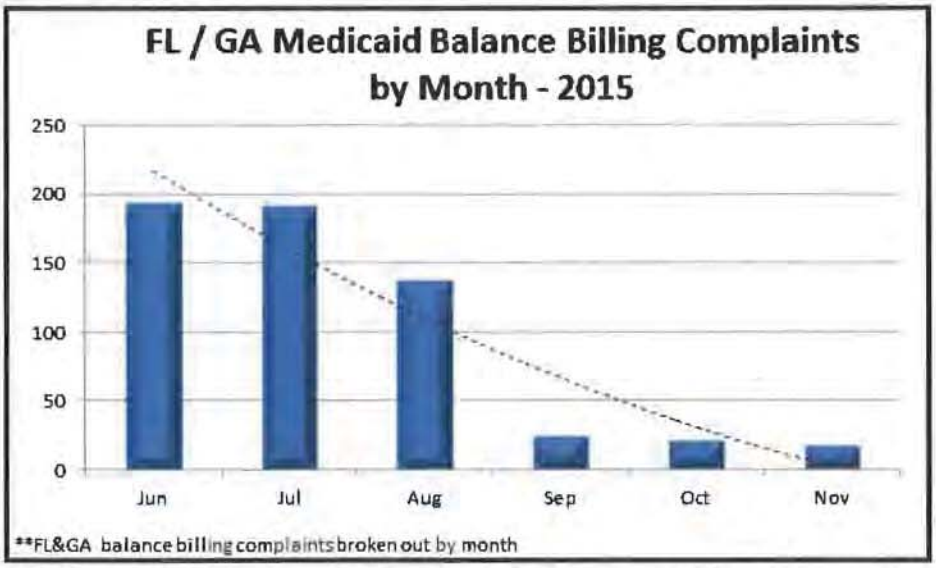
Family Planning

Members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside of our provider network without restrictions and without referral. The out-of-network provider submitting a claim for family planning services will be reimbursed at no less than the Medicaid rate in effect on the date of service. To ensure continuity and coordination of a member's total care we encourage members to receive family planning services from in network providers through all avenues of member education including the member handbook, newsletters, member services, care managers, and member outreach.

Oversight Process to Ensure Prompt Resolution of Issues

We closely monitor out-of-network claim payments to assure prompt resolution of any issues that might arise. One of the key payment issues we have found with out-of-network providers is balance billing. We addressed this by establishing an outbound call unit to work directly with provider offices when a member calls regarding a balance billing issue. Our member services associate takes the information and a call is initiated to the provider's office to educate them on the prohibition against balance billing and work with them to identify the root cause and underlying issues. This new program began August 2015 as a pilot for our Florida and Georgia plans. Since that time the team has received positive feedback from providers about the proactive approach we are taking to resolving provider concerns and has mitigated 99 percent of all calls related to balance billing.

Figure 4



Our outbound call program was rolled out to the remainder of our Medicaid plans in October and will be in place at time of program implementation for the Heritage Health Plan. See **Figure 4** for a pilot program performance results.

SECTION IV.Q PROVIDER REIMBURSEMENT

100. Describe the MCO's proposed process for the annual year-end cost settlement process with critical access hospitals. *(Page limit 1 page)*

ANNUAL YEAR-END COST SETTLEMENT WITH CRITICAL ACCESS HOSPITALS

WellCare has extensive expertise in contracting and reimbursing critical access hospitals, including the cost settlement process. In compliance with 471 NAC 10-010.03F and 10.010.06A, WellCare will make critical access hospital inpatient payments using interim per-diem rates calculated by MLTC with an annual year-end cost settlement. We will reimburse outpatient critical access hospital services based on a cost-to-charge calculated by MLTC with an annual year-end settlement. For the purposes of this RFP, critical access hospitals are those listed on Attachment 16, or as amended by MLTC.

Proposed process

WellCare proposes the following process for annual year-end cost settlement process with critical access hospitals.

- To accommodate the Medicaid cost reporting requirements for Nebraska critical access hospitals, WellCare will provide a paid claims report to each facility and MLTC 120 days after the end of each hospital's fiscal year. Generally, 120 days is the typical timeframe needed to produce a paid claims report to accommodate 90 days claims runout.
- The paid claims report will contain both inpatient claims and outpatient claims with service dates occurring during the hospital's fiscal year and paid from the first day of the fiscal year through at least 90 days after the end of the fiscal year. The paid claims report will be provided to the hospital within 120 days of the hospital's fiscal year. Another updated report will be provided 14 months after the fiscal year ends.
- The paid claims listing will contain both covered and non-covered charges identified by cost center using revenue codes. Payments made by WellCare will be listed along with any third party liability payments and member cost sharing. For inpatient claims, both the discharges and days will be included on the report.
- Once WellCare receives the final Medicaid cost report from the Department of Health and Human Services (DHHS) Financial Services, the cost to charge ratio for each cost center will be applied to the covered charges to calculate reasonable cost of services for each cost center. The reasonable cost for each cost center will be compared to WellCare payments plus any member cost sharing amounts to determine whether any additional payment is owed to the critical access hospital or due back to WellCare. Third party liability (TPL) claims and any services that are not reimbursed on a cost basis, such as flat triage fees or outpatient services paid on a fee schedule, will be excluded from the settlement calculations.
- The settlement calculations will be communicated to the hospital for final reconciliation.

SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

101. Provide a general system description that details how each component of the MCO's health information system will support the major functional areas of NMMCP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements.

Describe how the MCO's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the MCO's systems. If modifications or updates or updates are required, describe them and the MCO's plan for completion prior to program operations. *(Page limit 12 pages, not including the systems diagram)*

DEPLOYING AN INFRASTRUCTURE THAT IS INTEGRATED, ADAPTABLE AND MEMBER-CENTERED: WELLCARE'S APPROACH TO INFORMATION SYSTEMS

WellCare's single-instance, fully integrated management information system (IMIS) platform, which is fully scalable and flexible, is used today to collect, analyze, integrate and report data in support of our entire operating book of business serving 3.7 million members, including Medicare Advantage in 15 states, contracts in nine Medicaid states, Part D operations in 33 regions (49 states and the District of Columbia), and two Health Insurance Exchange markets. We plan to leverage this IMIS application suite to support all aspects of the Heritage Health program including but not limited to; enrollment; care management; utilization; claims adjudication and payment; grievance and appeals; disenrollment. Our systems provide the business capabilities to meet all requirements as outlined in *Section R. Systems and Technical Requirements* of the program description and scope of work of this Request for Proposal (RFP), and we are committed to meeting the needs of MLTC, our Heritage Health members and providers through continued investment and enhancement of our technology platforms. We acknowledge that reporting formats will be determined by MLTC post contract award.

WellCare's IMIS suite supports all the aspects of our processing requirements, including those specified in the *Section R. Systems and Technical Requirements* of the RFP, and consists of applications that:

- Provide a stable, secure and standard technical architecture
- Focus on the care and Utilization Management, needs and preferences of the individual members
- Support the establishment of an available, accessible and adequate provider network
- Are built on a base platform that efficiently completes routine functions such as Enrollment & Disenrollment Processing, Claims and Encounter Processing and Financial Management
- Incorporate robust complaint, Grievance, Appeals and Dispute processing
- Utilize a Data Management Solutions to collect, assembles and make available in a meaningful way the information needed to support reporting, analytics and data exploration

Our applications support accessibility by separating the user interface, process workflow, application functionality and data management functions into clear, distinct layers that allow for the delivery of functionality to members, providers and internal users through multiple channels. The IMIS is designed and built to leverage configuration changes by business users that permit them to modify, enhance and improve the behaviors and functionality of the applications without application code changes. Our IMIS suite of applications also interact with one another through defined functional enterprise services while implementing "publish and subscribe" methods to ensure updates and changes in data or activities are known to all applications. The system diagram (see **Figure 1** on page 13) outlines the key system applications that will be used to support our Nebraska operation.

SUPPORTING THE MAJOR FUNCTIONAL AREAS OF NMMCP

The flexibility, structure and focus of our application environment aligns with the emphasis that both WellCare and MLTC places on the holistic management, delivery and support of individual, personalized care. In **Figure 2** on page 14, WellCare outlines the ten key application components of the IMIS, which are described below:

Digital Solutions

WellCare leverages technology to facilitate our interactions with members, providers and government partners to provide multiple methods of effective and efficient communications and facilitate cost effective health care transactions. Key Components of our Digital Solutions include:

- **Corporate Website:** WellCare's corporate website is accessible to all users without the need for login credentials. Examples of information available from the corporate website includes: information on WellCare's Medicaid health plans, links to WellCare's MLTC's website(s), WellCare corporate history and contact information, and WellCare's corporate values and goals. Additionally, all public website locations on WellCare include the ability to search for and find providers.
- **Member Web Portal**: WellCare's web portal for members (including caregivers supporting individuals) are designed to enable interactions with Members, provide access to information and complete routine transactions. The portal provides access to information such as Pharmacy preferred drug lists, over-the-counter OTC benefit information, a searchable Member Handbook, a Formulary lookup, Health and Wellness materials, accessing interpreter services, and other member materials. Members are able to complete transactions such as provider searches, PCP selection and changes, and requesting materials, including ID Cards. The site also features a member messaging (including communications delivery and Contact Us features) and communications history. WellCare also utilizes the site to improve member awareness by including reminder information for Medicaid redeterminations and informing members about Care Gaps.
- **"MyWellCare" Member Mobile Application:** Our MyWellCare mobile application for members is available for Apple and Android smartphone devices. The application is designed to make it easy for members to interact with WellCare when and how they want. Key features include: Find-a-Provider, Quick Care (Urgent and Hospital Emergency service locator), Contact Us, ID Card, Wellness Services (Care Gap) notifications and alerts when a member is due for a check-up.
- **Provider Web Portals:** WellCare's web portal for providers enables access to various materials and tools to obtain information and perform day-today tasks. Our provider portal includes information such as a Searchable Provider Handbook, Member Benefits, and the Appeals and Grievance process. The portal also facilitates transactions including; allowing providers to request and receive prior authorizations, Searchable Provider Directory, Request and Receive Prior Authorization of Services, support for Claims Submission/Corrections/Status Inquiry, Membership Verifications (including Eligibility, Co-payments), a member roster for PCPs and the ability to submit questions.
- **Government Partner Web Portal:** Our Government partner portal was initially dedicated to providing State agencies access to reports and performance information including weekly, monthly, quarterly, annual and ad hoc reports, quality and performance reports. This portal is a supplement to, and not a replacement for, standard file transfer (FTP) and other communication channels.
- **Interactive Voice Recognition** (IVR): Our IVR enables members and providers to gain access to the information they seek and to perform routine transactions in an automated manner. The provision of claim status information, requesting an ID card and even ordering OTC supplies are frequently used services provided through the IVR.

Provider Management

WellCare's provider management applications support the essential functions of identifying, credentialing, contracting with and maintaining healthy and productive relationships with a broad network

of providers and community agencies. Each step in our provider management process includes data and quality review to ensure that WellCare is continually able to provide an accurate, current, and up-to-date provider directory to our members and providers. Examples include an address verification processes to verify that physical and mailing addresses are accurate and usable for correspondence, GeoAccess® verification and even the provision of driving directions. The provider management application supports the requirements outlined in Section *R.8 Provider Enrollment* of the RFP, including:

- Maintenance of audit trails.
- Retention of key data elements (including NPI, provider affiliations, office hours, languages spoken, disability accommodations).
- Provider contractual arrangements, including linkages of individual providers to groups.
- Individual providers from contractually-delegated providers including pharmacy, vision, transportation, and other providers.
- Credentialing functions including data capture and automated alerts, including system generated letters delivered through the member and provider communications module, when licenses are expiring. WellCare's credentialing application (Cactus) includes automated interfaces to multiple sources, although many state licensing and medical boards do not support electronic interfaces and require manual validations.
- Network Integrity capabilities including the ability to monitor and ensure compliance with geographic access requirements. This automatic process provides monthly validation against multiple exclusion sources to ensure no excluded individuals are included in the network or otherwise paid by WellCare.

WellCare will provide a weekly provider file in the format and including the content specified by MLTC. We will utilize the provider type and specialty codes specified by MLTC in the communication and exchange of provider data with MLTC.

A unique aspect of WellCare's provider applications is the support for community providers through the **Health*Connections* databases**. At the core of the Health*Connections* model is the concept that the social service network is a vital component of the healthcare delivery system. With this in mind, WellCare uses traditional public health methods to research and catalogue available community-based programs, activities and services that comprise the social safety net. WellCare CommUnity Liaisons load the network into a centralized CommUnity Command Center that is accessed by member-facing and community-facing representatives to search for available services and record the referral in a social service electronic health record (SSEHR). This SSEHR maintains information for each caller on all referrals and their disposition. WellCare then uses several to profile the network at a macro- and a micro-level: service area, breadth and scope of services offered, strength of funding sources, and consumer feedback (quality). This information is then overlaid with population, referral, network gap and census data to compare availability with need.

Care Management

Our Medical Management Platform (MMP) application is utilized to support the care management and utilization management functions of our member populations, and our Drug Enhancement Request (DER) application performs formulary utilization management functions to ensure members receive the appropriate treatment. The MMP supports our assessment, stratification, planning and care coordination functions for all phases of Utilization (UM), Care Management (CM) and Disease Management (DM). MMP provides the foundation for the development of a customized care management and care coordination system to provide person-centered care management and care coordination services to our members. It is a person-centered platform that enhances care integration among all places and levels of care, and it optimizes continuity of care. MMP supports both online (connected) and off-line modes. This means that when our clinicians and care managers are in the field, they have access to MMP functionality in support of our members. The MMP supports the capture of information from Health Assessments,

Predictive Modeling and Risk Stratification sources to identify and reach out to members that are in need of or would benefit from Case and Disease Management planning. The MMP also provides the support for critical care management staff activities such as Care Coordination and Oversight, Service Plan Development and Goals Tracking. The application provides care management staff with insights into data such as Immunizations, Care Gaps, claims, and other data through a comprehensive member 360 view. Utilization Management is also supported by the MMP and incorporates automated integration with clinical guidelines to help ensure patient safety and the best health outcomes. The DER application is similarly utilized to support the evaluation of requests for formulary enhancements and includes integration with review criteria. Both the MMP and the DER applications automatically update the claim adjudication system with approved service requests.

Claims and Encounters

WellCare's Core Processing System (CPS) is the hub of our Information Systems suite. The CPS is designed to apply benefits, clinical edits, provider contract and pricing, data validations and service code verifications (including NCCI edits), and authorization rules to claims in a real-time processing environment. This capability allows WellCare to meet or exceed the timeliness and accuracy standards identified in the RFP. Encounter submissions, including claims (medical, pharmacy and ancillary) from delegated vendors are all processed through the Encounter Processing System which ensures completeness through validation against Cash Disbursement Journals, as well as compliance with state companion guides for encounter submissions, and management and resubmission of any submission rejections. We successfully transmit encounter data in 13 versions of Encounter formats (837I/P/D, NCPDP, PACDR, APAC, etc.) for 22 lines of business. WellCare currently submits six million encounters per month.

Enrollment and Eligibility

WellCare is successfully processing an average of over 8.4 million enrollment and disenrollment transactions per month from daily and monthly 834 files from nine Medicaid states in 2015 (January 1,2015 through October 30,2015). WellCare's Enrollment and Eligibility System (EES), further described in the response to Question 104, will meet the obligations for processing enrollment outlined in *Section R.5 Eligibility and Enrollment Data Exchange of* the RFP, including the receipt and processing of enrollment files within 24 hours of receipt, transmitting to MLTC, in the formats and methods specified by MLTC, change of member address and telephone number, the ability to identify member's by their Medicaid ID, and execution of validations to identify and resolve potential duplicate records in coordination with MLTC and as specified by MLTC. WellCare's EES application supports multiple edits and validation on the incoming 834 data during the processing stages including comparisons to existing records using names, Medicaid or other IDs, and date of birth to prevent loading duplicate records. Because the EES application performs all validations (including potential duplicates), tracks each member separately, and requires manual confirmations prior to loading, WellCare is not only able to ensure accurate system updates but also support notification and interaction with MLTC for duplicate or other potential member data issues. WellCare will submit monthly member Data Conflict Reports in accordance with MLTC defined guidelines and formats.

Complaints

Our complaints module, which is used to support Appeals and Grievances, is directly integrated with the CareConnects customer service application, supports a notice of action process and an expedited resolution process. This single solution assists coordinators in capturing all data and information necessary to ensure prompt review and follow up of submissions. It also supports a notice of action process and an expedited resolution process. In 2014, these processes were found to be 100 percent compliant with National Committee for Quality Assurance (NCQA) standards.

Member and Provider Communications

WellCare's Corporate Communications Module (CCM) serves as the communications hub for the

effective distribution of communications to members and providers. This platform is used to meet the requirements for member and provider material distribution, including distribution of materials according to the recipient's delivery preference (USPS, email notification and delivery to web portal) and the member's language preferences. The CCM indexes and makes accessible the communication history with members and supports interactions with the web, CAREConnects, MMP, and other applications to provide access to relevant communications efficiently and effectively. Included as part of the CCM is the ability to utilize templates to format communications and combine (mail merge) data into communications that are consistently formatted with State-approved communication formats.

Member and Provider Services

WellCare's CAREConnects application, our member and provider service solution, is a rule-based contact management system. CAREConnects is the single user interface and navigation tool used by WellCare's member services and provider services staff. The CAREConnects solution improves the quality of call handling, ensures consistency of services, facilitates first call resolution, reduces handle time and allows us to more effectively assist members and providers. It aids in the identification of training needs thereby increasing its effectiveness, which in turn, increases associate effectiveness. These benefits result from application's guiding member and provider service representative's interactions through scripted wording. Scripts increase quality and accuracy, and using workflows for each type of interaction scenario automates many of the actions to be taken, and provides real-time access to member, provider, claims, and authorization information.

Financial Applications

The basic financial management of accounts payable (AP), accounts receivable (AR) and general ledger (GL) activities are supported through WellCare's Oracle® financial applications. The financial applications serve as the system of record for revenue and expense transactions and the generation of corporate financial statement information.

Quality Applications

Our quality applications are predominantly data and analytics driven solutions that meet formal regulatory reporting needs and are primary examples of how we leverage data sources to integrate information into our daily operations. The quality applications support effective care management processes. They are also used to support Healthcare Effectiveness Data and Information Set® (HEDIS) reporting, which utilizes data from all available sources, including non-operational sources, to generate data and information. This information is compiled completely, and these sets of data extracts are loaded into our HEDIS application to ensure that HEDIS scores are accurate and consider the comprehensive set of information available. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is supported through the use of member demographic information, claims, encounter and other utilization data to match against EPSDT and periodicity schedules which then determines those members who are in need of services. From HEDIS and EPSDT processing, we identify Care Gaps information which is available to care managers, providers and members. WellCare is also actively enhancing its provider profiles capabilities, which extract multiples types and sources of data and generates as output a Data Mart that is accessible for reporting, analysis and display on the secured provider web portal.

Our Care Gaps approach is structured and designed to provide maximum benefits to our members.

Our Integrated Design Focused on Member Outcome

Our Quality application is focused on identifying the basic care services members should obtain and creates Care Gaps for those services. In addition to traditional methods such as member letters, WellCare

makes these Care Gaps visible to members on the member portal and the Mobile App. We also make these Care Gaps visible to our providers on the provider portal. The Care Management application not only provides care coordinators with access to Care Gaps, it highlights them. Our customer service agents are notified through the CAREConnects application when a member has Care Gaps in an effort to help them schedule appointments.

SHARING INFORMATION BETWEEN MLTC AND OUR SYSTEM WHILE AVOIDING DUPLICATION

WellCare coordinates system activities and information exchanges with Medicaid states to ensure timely, accurate and efficient processes and exchanges of information that avoid duplication of efforts. As an example, WellCare recognizes that the state (or its Enrollment Broker) is the source of truth for enrollment and eligibility information. WellCare's EES application is designed to efficiently process information received from the State and align our enrollment database to the information from the State. In markets where the functionality is supported, WellCare provides a reconciliation file to the State to ensure valid processing results. During the processing of 834 Enrollment files, should a member's PCP selection be communicated, we will utilize that information to assign members to their chosen PCP. WellCare also has implemented other system integrations with Medicaid states to improve efficiency and eliminate redundancy. A primary example is the creation of an interface to receive Authorization Requests directly from a State web portal. This allows providers to have a single interface for use across all MCOs and eliminates the creation of multiple portals. Another example is our support for a Common Verification Organization, operated by the State which serves as a single source for credentialing of providers in the State. This streamlines provider credentialing by multiple MCOs. WellCare is supports and has actively participated in such integrations.

We will utilize the formats prescribed by the State of Nebraska for the exchange of enrollment (834s), capitation payments (820), provider data (proprietary) and encounter submissions (837, NCPDP) and make payments to providers using EFT transactions.

WellCare is the only known MCO to send participants to the annual HIE Users group meeting in Park City Utah.

As part of our commitment to government sponsored health care initiatives, WellCare has been actively engaged in working with our State partners on a Healthcare Information Technology (HIT) strategy since 2012 when we prepared to integrate with the Kentucky HIE. Our care model is *"the right care at the right time, in the right setting."* To that end, making good data available to our care managers is of primary importance. HIT helps us by integrating data from a wide variety of sources and providing data on a wider scope than is possible for an individual managed care organization. HIT often provides information more quickly. WellCare has been and will continue to be an active participant in the HIT community. During the *Health Information Exchange Users Group (HUG)* conference (September 28 -30, 2015) WellCare was the only known MCO to send participants to the annual HIE users group meeting in Park City Utah. We are now preparing to work with any interested HIEs to find mutually beneficial solutions for our common problems. The Nebraska Health Information Initiative, NeHII, requested that WellCare provide input to their annual strategy meeting. WellCare firmly believes in promoting the use and adoption of State HIEs as a benefit to the industry, and we actively promote adoption by our contracted provider network as well.

Access to Systems Information

WellCare will provide a dedicated Government Partner Portal to MLTC for the placement and delivery of required weekly, monthly, quarterly and annual reports, and ad hoc reports. We are already in the process of enhancing this portal with additional self-service capabilities which will include access to member claims and other system information in a transparent and user friendly manner. We are making this enhancement to support the request for access to live systems identified in section *R.1c Systems and*

Technical Requirements of the RFP, while continuing to ensure compliance with privacy and security concerns for all our constituents and reducing training and complexity for our government partners. Nebraska authorized users will be provided access to WellCare system information through our secure portal, in accordance with the security requirements outlined in *Section R.9 Information Security and Access Management* of the RFP.

Process for ensuring Quality, Accuracy and Completeness of reporting

WellCare's corporate emphasis and culture of compliance is demonstrated by the manner in which our system designs, software development lifecycle, and regulatory report submission processes focus on ensuring quality, accuracy and completeness of reporting.

Our enterprise Data Management Solution provides the Information Technology (IT) infrastructure to support our integrated system of care and gives WellCare a central repository of all our data. This centralized platform provides an one-stop shop to maintain compliance with MLTC's reporting requirements. Because of this structure, the data management solution is able to provide our staff access to any and all relevant member information including assessments, physical and behavioral health services, pharmacy, lab/imaging test results, care management activities, integrated care plans and service plans. We have a successful record of complying with the reporting requirements of governmental agencies in 49 states and the District of Columbia. These reports are developed in accordance with contract requirements and state and federal reporting guidelines and are automated to ensure accuracy and timely delivery. We use a formal compliance tracking tool to monitor reporting requirements and track completion. This tool sends automated messages to alert report preparers prior to reporting due dates and records submission for reporting of timeliness metrics.

As outlined in more detail in the response to Question 102, WellCare supports all standard data exchange formats, including those for collecting service information from providers, as outlined in *Section R.1b. Systems and Technical Requirements* of the RFP. WellCare publishes standard Companion Guides on its website. In addition WellCare's operations units dedicate a team to monitoring and working with providers to effectively implement data exchanges, including working with paper submitters to implement standard electronic interfaces.

Report Methodology

WellCare follows the (Refer to **Figure 3**) software development life cycle for report development as noted in the table below.

Figure 3

Planning Phase	During the planning phase, we gather and document all specifications and instructions required for each regulatory reporting submission. This includes the identification of the inter-disciplinary team responsible for the implementation of the infrastructure to facilitate the generation and submission of all deliverables. These planning efforts are documented in the Legal Integrated Online Network Solution (LIONS), which is used to monitor our reporting submissions. IT report preparers conduct data collection sessions with different functional area owners within the organization to map the data elements in our systems to the data that is required in the reports. Our IT associates also document the business process and the data transformation process that is needed to fulfill the reporting needs. The functional areas may include, but are not limited to, enrollment, claims, encounters, grievances and appeals. The requirements are approved by the data source providers prior to starting the design phase.

Requirement Phase	During the requirement phase, the IT report preparer with the assistance of a cross-functional team that consists of the business report owner, functional process owners and other IT system owners, completes the Business Requirement Document.
Design Phase	During the design phase, the IT report preparer designs the report structure and the technology platform. The report is also finalized during the design phase.
Construct Phase	During the construct phase, the reports are developed based on the approved requirements and design. Developers review and validate that the report is functional through the unit testing of the code. Unit test results are documented before the reports are handed over to the Quality Assurance (QA) team for additional testing.
Scheduling and Review	During the scheduling and review phase, the report creation process is automated, and reports are scheduled to run for review and approval by the functional area owners before they are due for submission. We have the capability to submit the reports either through a secure FTP, secure email or any other process as defined by the state.
Maintenance	During the maintenance phase, the reports are periodically reviewed to ensure accuracy and completeness of the information being provided.

Process of Reviewing Reports

Our reports are categorized as **fully automated or partially automated.** As part of the system development lifecycle we test fully automated reports for accuracy prior to being put into production. Partially automated reports have a component that is automated but require some human intervention (review, analysis, additional comments in narrative form, etc.) before they are considered complete.

Legal Integrated Online Network Solution (LIONS)

We use the Legal Integrated Online Network Solution (LIONS) application to manage the internal review and validation of regulatory reports. LIONS is an internally developed web-based application designed to effectively control, track and monitor regulatory reports, ad hoc submissions and other deliverables. The Regulatory Affairs department, in conjunction with corporate Compliance, maintains this application and ensures it is updated. The LIONS application stores all report deliverables including the report type, frequency, report requirement and specifications, regulatory agency, due dates, reminder features, responsible parties, submission method and associated fines or liquidated damages. Concurrently with the configuration of LIONS, the management team within the Regulatory Affairs department assembles a regulatory reporting work group that works on the individual planning and implementation of each regulatory report. This work group is comprised of professionals from the IT department, subject matter experts from business units and other interested parties.

LIONS is an internally developed web-based application designed to effectively control, track and monitor regulatory reports, ad hoc submissions and other deliverables.

Our reporting policy defines specific roles and includes an attestation process for all required reports. As each report is defined in our compliance tracking tool, the following roles are defined (**Figure 4**).

Figure 4

Data Source Provider	➢ Individual with direct knowledge of the data used in report ➢ Responsible for specific data sources and data supplied to the report preparer
IT Preparer	➢ Associate within the IT department ➢ Works with report preparer, data source provider and regulatory owner ➢ Establishes report control document and requirements document
Regulatory Owner	➢ Associate responsible for defining the report specifications ➢ Measures compliance based on regulatory and contractual requirements ➢ Clarifies reporting requirements with state or federal regulatory agency, as needed
Report Preparer	➢ Compiles final report ➢ Certifies the report prior to submission or required sign off

Ad Hoc Reporting

WellCare will comply with requests for ad hoc reports from government partners through coordination with a Request Manager (typically either our Nebraska-based Compliance Liason or Information Management and Systems Director). All requests will be immediately logged in our tracking application and forwarded to our Regulatory Reporting team for discussion. All reasonable attempts will be made to meet or exceed the requested MLTC timelines. Our experience indicates that on occasion, the nature and complexity of the request may not be feasible within a five-day or other requested timeframe. In such cases, WellCare's Request Manager will notify MLTC of the challenge and the most aggressive, viable timeframe for delivery.

Resource Availability and System Changes

Service Desk requirements, as outlined and required in *Section R.3.1 Resource Availability and System Changes,* are included in the response to question 103, which addresses the timelines, support methods, and tracking requirements identified in the RFP.

Systems Policies and Procedures

WellCare's corporate compliance department oversees and maintains a repository of all corporate policies and procedures. Included in this repository are topics outlined in *Section R.3b Resource Availability and System Changes*, including, but not limited to, policies that address security and IT operations:

- C13IS.01.011.ST-001 – WellCare Information Security Standard
- C13IS.01.011 – Information Security Policy
- IT.001-PR-111 – IT Job Operations Management Procedure

WellCare's corporate training department coordinates the development and review of training materials for end users, incorporating both system and job function training to ensure that end users are educated on the use of IT Systems. WellCare's C2TR-001 Corporate Training Requirements policy is the primary policy governing training activities, including governance of training materials. We also make available to web users Help functions and documentation to assist users in site access and navigation.

System Changes

With respect to the requirements established in RFP *Section R.3c System Changes*, WellCare has implemented formal processes for the identification, development, testing, and promotion of system changes and maintenance as required, including changes for federal or State mandated formats, actions, or operational activities, such as those supporting the Encounter Submission process.

WellCare's release management process is designed to ensure stability in the production environment

while enabling timely delivery of needed functionality into production. We acknowledge our responsibility to notify MLTC at least 90 calendar days prior to the installation or implementation of minor software and hardware upgrades, modifications, or replacements. This also includes notifying MLTC prior to the installation or implementation of major software and hardware upgrades, modifications or upgrades (including, but not limited to, claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management, conversions of core transaction management systems). Our current practice is to publish the release schedule for a calendar year in advance of the start of the year. WellCare's 2016 release schedule was published in December 2015.

Each upgrade or system change will be documented in a release plan that includes a timeline, milestones, and adequate testing to be completed before implementation. We acknowledge our responsibility to provide such plans to MLTC, when requested, in the timeframe and manner specified by the MLTC. Our Intake process is initiated upon the issuance of new or revised requirements from the state, CMS, or other regulatory agencies as well as during the annual planning process. An Intake Request is generated and used to track any change request throughout the entire life cycle. Intake Requests are routed to the appropriate WellCare executive for review, clarification, and prioritization. Regulatory and contractual changes receive the highest priority. Once changes are approved, the request is initially scoped and sized. As appropriate, architectural impact, business requirements, and functional specification documents are created for the request. The Intake Request is then scheduled through the release planning process. The release planning process assigns target release dates, ensures related changes are coordinated, and establishes the lifecycle delivery dates for each stage of development.

WellCare establishes the Information Management and Systems Director, identified as key personnel in the RFP, as the primary liaison to Government Partners such as the MLTC for all IT activities. The Information Management and Systems Director will coordinate with the project management office to communicate corrections, target deployment dates and provide any requirements or analysis information as appropriate. He/She is also accountable for the reporting of system availability or performance issues, status and resolution updates as outlined in *Section R.3 (e-g, k) Resource Availability and System Changes* of the RFP. WellCare's change management policies and procedures ensure that changes to production environments are documented and approved. WellCare's release schedule establishes timelines for deployments and enhancements, and changes involving outages are planned for non-production hours. The Information Management and Systems Director will coordinate any variances from this schedule with the MLTC. He/She will also work with the Project Management office to coordinate testing activities with the MLTC as appropriate.

Systems Refresh Plan

We will continue to invest in the development and enhancement of the IMIS platform to ensure ongoing compliance with federal and MLTC-specific requirements, to enhance our internal efficiency and, most importantly, to better serve the individual needs of our members and our provider community. Our business units plan for enhancements to our system annually through a Capital Planning Process, taking into account industry trends, needs of the MLTC, enterprise best practices and feedback obtained from members and providers. The Key Production System matrix included in the Systems Overview diagram (Figure 4) outlines the platforms and versions of hardware in use and is maintained on an ongoing basis. WellCare will ensure that vendor supported versions of third party solutions is maintained.

Other Electronic Data Exchange

WellCare currently leverages technologies, such as our website, mobile application and social media, to distribute critical member information and interact with our members. We have launched and funded a new strategic initiative to implement additional uses of technology that will further enhance member communication and engagement. Over 2015 and 2016, we will deploy the following three components of our innovation initiative (**Figure 5**).

Figure 5

OUR INNOVATION INITIATIVE
➢ We will leverage scanning and indexing technologies to better store, retrieve and disseminate inbound Members faxes and emails. This enhancement will result in the creation of a member communication record that will include inbound member communications. All of our member-facing teams will be able to provide an enhanced, more coordinated level of service by being able to quickly access all communications from members.
➢ The second component, scheduled for release in 2016, also focuses on using technology to make correspondence available to our member and member-facing staff. This component focuses on retaining and associating WellCare initiated outbound correspondence to the member communication record. The member will access the member communication record via our secure member portal to review correspondence sent by WellCare to the member. Members who supply an email address and specify email as their communication preference will receive an email notification of new correspondence being available in the member portal and will retrieve their correspondence via their secure account on the portal. This approach provides an effective alternative to surface mail and protects member privacy.
➢ In 2016, we will implement text notifications that a new correspondence has been generated and is available via the member portal. In the same release we will deploy chat capability on our secure member portal.

Electronic Messaging

WellCare will establish a continuously available electronic mail communication link (email system) to facilitate communication with MLTC, based on its installed version of Microsoft Office. As a normal course of operations, WellCare establishes a secure FTP site with government partners for the exchange of data files and can communicate using a secure virtual private network (VPN) while complying with national standards for submitting protected health information (PHI) electronically. WellCare also provides for reports and other forms of content exchange a password-protected government partner portal.

Records Retention

WellCare's C13RIM.001 Records and Information Management Policy governs the maintenance and retention of records in WellCare data systems. WellCare has reviewed, acknowledges, and will comply with the retention requirements outlined in *Section R.13 Record Retention* of the RFP.

ENHANCEMENTS TO OUR SYSTEM TO MEET THE REQUIREMENTS

Requirements specifically outlined in the RPF that have been identified as needed for future development, and will be developed upon Contract award are as follows:

Full Participation in NeHII: WellCare has independently initiated corporate activity and integrations with other states to support participation in Health Information Initiatives. Upon award and the receipt of appropriate operating guidelines, we will implement requirements on an agreed upon timeline to support direct NeHII integration.

Regulatory Reporting & Submissions: Reporting formats will be determined by MLTC post contract award as noted in the RFP. As a result in our response WellCare has provided significant detail around the report generation and certification processes to demonstrate that we fully understand and support these obligations. While we produce a large number of regulatory reports in support of our nine Medicaid states, we fully anticipate additional development efforts to implement the specific reporting and formatting requirements as defined by MLTC.

In addition, we continually invest in the development of and enhancement of this platform to ensure we comply with the requirements of MLTC to enhance our internal efficiency and, most importantly, to better serve the individual needs of our members, government partners, and provider community. Prior to

and independent of the issuance of this RFP, WellCare initiated multiple internal system and solution activities which contribute to functionalities identified in this response. These activities include:

- Key strategic functions including our web portal (for all constituents)
- An innovative Medical Management Platform (MMP)
- Enhancements to our Data Management Solution platform, including predictive modeling, reporting and analytics
- Enhancements to the Provider Management Platform
- Installation of a robust correspondence platform (including support for a broad array of member preferences)

Beyond the system activities discussed above, WellCare has noted initiatives within the RFP that will result in our engaging in new creative solutions that enable us to effectively meet our Members' needs in a holistic and comprehensive manner. Key enhancements to our operations based on these initiatives are scheduled for completion in 2016 and include:

- **Enrollment and Eligibility System (EES) Enhancements:** Our EES is being modified to support the optional selection of a Behavioral Health Home. These changes will include capturing member permission to share behavioral health information with the PCP, separate member correspondence confirming Behavioral Health Home changes and notifications of PCP changes to Behavioral Health providers.
- **Expanded Access to Community and Safety Net Provider Information:** We currently collect and make available to Care Management and our other users vast amounts of information on Community and Social Safety Net Providers to assist our members. We will be extending access to this information to providers-specifically Behavioral Health providers in Nebraska.
- **Government Partner Portal Enhancement**: We are making modifications to the portal application which includes the ability to submit Service Tickets, and access WellCare system information. We would solicit other suggestions or recommendations from MLTC on opportunities to make this portal even more beneficial.
- **Enhanced Medical Management Platform:** WellCare is already in the process of developing and deploying an enhanced MMP which will improve the use and efficiency of the application. While the current platform meets or exceeds the requirements outlined in this RFP, completion will further extend and expand the functional capabilities of our Medical Management platform.
- **Web Portal Project:** Similarly, WellCare's web portal project will be extended to expose additional member care gaps (including EPSDT and immunization services) to providers, and we will be making this functionality available to all appropriate providers as well as members as part of, or in advance of, the effective date of the planned contract. Moderate additional content and functionality will be added to this portal to ensure compliance with the requirements as outlined in Question 49 of our response "provider website".

Figure 1

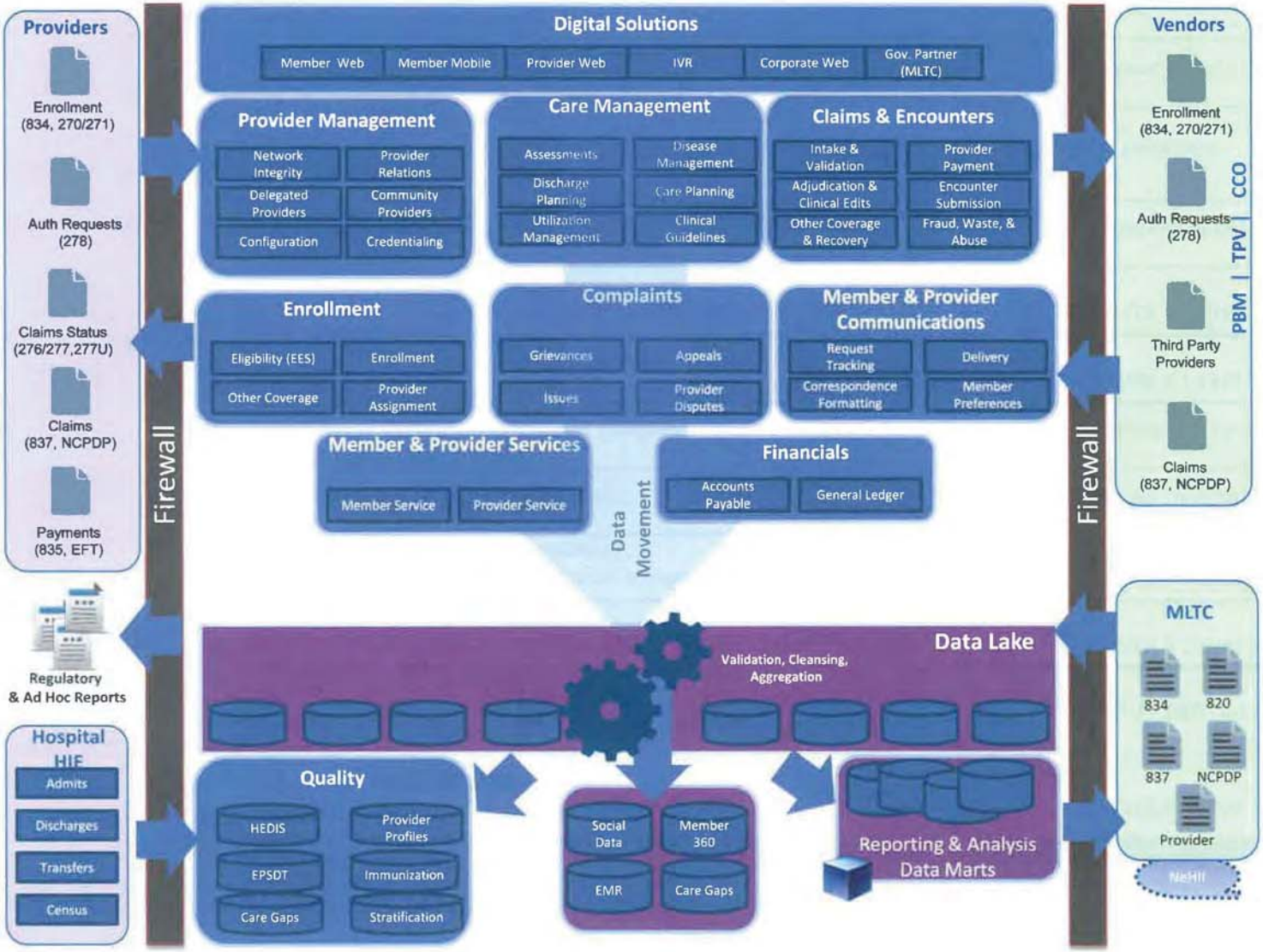

Providers
Enrollment (834, 270/271)
Auth Requests (278)
Claims Status (276/277,277U)
Claims (837, NCPDP)
Payments (835, EFT)
Regulatory & Ad Hoc Reports
Hospital HIE
Admits
Discharges
Transfers
Census
Firewall
Digital Solutions
Member Web
Member Mobile
Provider Web
IVR
Corporate Web
Gov. Partner (MLTC)
Provider Management
Network Integrity
Provider Relations
Delegated Providers
Community Providers
Configuration
Credentialing
Care Management
Assessments
Disease Management
Discharge Planning
Care Planning
Utilization Management
Clinical Guidelines
Claims & Encounters
Intake & Validation
Provider Payment
Adjudication & Clinical Edits
Encounter Submission
Other Coverage & Recovery
Fraud, Waste, & Abuse
Enrollment
Eligibility (EES)
Enrollment
Other Coverage
Provider Assignment
Complaints
Grievances
Appeals
Issues
Provider Disputes
Member & Provider Communications
Request Tracking
Delivery
Correspondence Formatting
Member Preferences
Member & Provider Services
Member Service
Provider Service
Financials
Accounts Payable
General Ledger
Data Movement
Data Lake
Validation, Cleansing, Aggregation
Quality
HEDIS
Provider Profiles
EPSDT
Immunization
Care Gaps
Stratification
Social Data
Member 360
EMR
Care Gaps
Reporting & Analysis Data Marts
Vendors
Enrollment (834, 270/271)
Auth Requests (278)
Third Party Providers
Claims (837, NCPDP)
CCO
TPV
PBM
MLTC
834
820
837
NCPDP
Provider
NeHII

Figure 2

WellCare Key Production Subsystems Hardware and System Architecture Specifications					
Key Platform	**Key Functions**	**Enterprise Application**	**Hardware Platform**	**OS Platform**	**Database Platform**
Enrollment	➢ Enrollment Master ➢ Enrollment Processing ➢ Eligibility ➢ Other Coverage ➢ Provider Assignment	Core Processing System (CPS)	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
		Enrollment and Eligibility System (EES)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
Provider Management	➢ Provider Master ➢ Network Integrity ➢ Provider Relations ➢ Delegated Providers ➢ Community Providers (HCBS) ➢ Configuration (Contracts)	Core Processing System (CPS)	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
		Third Party Vendor (Delegated)	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
		GeoAccess	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
		Provider Relations	Salesforce.com (hosted)	Salesforce.com (hosted)	Salesforce.com (hosted)
		HCBS Providers	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
Claims and Encounters	➢ Intake and Validation ➢ Adjudication and Clinical Edits ➢ Other Coverage and Recovery ➢ Provider Payment ➢ Encounter Submission ➢ Fraud, Waste and Abuse	Core Processing System (CPS)	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
		Claims Intake Systems (CIS)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
		RHEL 6 / IBM AIX 7.1	Oracle 12c	Pega Workflow	VMWare ESX – Cisco UCS/ IBM Power 795
		CES (Optum)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
		iHealth	Vendor Hosted	Vendor Hosted	Vendor Hosted

WellCare Key Production Subsystems Hardware and System Architecture Specifications					
Key Platform	**Key Functions**	**Enterprise Application**	**Hardware Platform**	**OS Platform**	**Database Platform**
		DRG/Pricers (Optum)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
		General Dynamics (STARSSolutions)	Vendor Hosted	Vendor Hosted	Vendor Hosted
		Encounters Processing System (EPS)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE MS SQL 2012 EE
Care Management	➢ Assessments ➢ Disease Management ➢ Discharge Planning ➢ Care Planning ➢ Utilization Management ➢ Clinical Guidelines	Medical Management Application (MMP)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2012 EE
		Pega (Workflow)	VMWare ESX – Cisco UCS/ IBM Power 795	RHEL 6 / IBM AIX 7.1	Oracle 12c
Member and Provider Services	➢ Request Tracking ➢ Delivery Formatting ➢ Member Preferences ➢ Delivery	CAREConnects	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2012 EE
		Global Navigator 4.05 (stats)	NECExpress/ 5800	SCO Unix	N/A
Complaints	➢				
	➢ Appeals (anticipated 12/31/2016)	Pega (Workflow)	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 12c
	➢ Grievances ➢ Issues ➢ Provider Disputes	Appeals and Grievances	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 12c

WellCare Key Production Subsystems Hardware and System Architecture Specifications					
Key Platform	**Key Functions**	**Enterprise Application**	**Hardware Platform**	**OS Platform**	**Database Platform**
Member and Provider Communications	➢ Request Tracking ➢ Delivery Formatting ➢ Member Preferences ➢ Delivery	Fulfillment and Communication System	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
		RightFax	VMware ESX – Cisco UCS	Windows 2008/2012	MS SQL 2008 R2
		Documentum	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	Oracle 11g EE
Financial	➢ Accounts Payable ➢ General Ledger	Oracle Financials	IBM Power 795	IBM AIX 6.1	Oracle 11g EE
Digital Solutions	➢ Member Web ➢ Member Mobile ➢ Provider Web ➢ IVR ➢ Corporate Web ➢ Gov Partner Portal	Web Content Management	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2012
		Web Pages	VMWare ESX – Cisco UCS	RHEL 5	MySQL 2012 Oracle11g EE
		Web Server	VMWare ESX – Cisco UCS	RHEL 5	MySQL 2012 Oracle11g EE
		Mobile (Droid)	Multiple (Droid)	iOS6.0 and above	N/A
		Mobile (iPhone)	Multiple (iPhone)	Android 2.2 and above	N/A
		IVR	ININ(Vendor Hosted)	ININ(Vendor Hosted)	ININ(Vendor Hosted)
Quality	➢ HEDIS ➢ EPSDT ➢ Care Gaps ➢ Provider Profiles ➢ Immunization ➢ Stratification	Quality Reporting System (QRS)	IBM Power 795	IBM AIX 6.1/IBM AIX 7.1	Oracle 11g EE
		Cave Groupers	VMWare ESX – Cisco UCS / IBM Power 795	RHEL 6 / IBM AIX 7.1	Oracle

WellCare Key Production Subsystems Hardware and System Architecture Specifications					
Key Platform	**Key Functions**	**Enterprise Application**	**Hardware Platform**	**OS Platform**	**Database Platform**
Data Management Solution	➢ Data Lake ➢ Application Data Marts ➢ Analytic Data Marts ➢ Extract, Load, Transform (ELT)	Data Lake (Raw Intake)	Cisco UCS	RHEL 6	Hadoop (Hortonworks Dist 2.1.7)
		Analytic Data Marts	Cisco UCS	RHEL 6	Greenplum 4.3.1
		Application Data Marts	IBM Power 795	IBM AIX 6.1 / IBM AIX 7.1	Oracle 11g EE
		Informatica PowerCenter	VMWare ESX - HP 495 Blades	Windows 2008 EE	Oracle 11g EE
Infrastructure and Security	➢ Firewall ➢ Alerting ➢ Virus Scanning ➢ Core Switches ➢ Scheduler ➢ Network Access Control ➢ Intrusion Prevention (IPS) ➢ Web & Spam Filtering ➢ Incident Monitoring ➢ Antivirus and Malware	Firewall	Cisco ASA 55xx-X, Palo Alto 50xx	ASA 9.2, 6.0.8	N/A
		Core Switches	Cisco Nexus 7010	NXOS 5.2(9)	N/A
		SCOM	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2008 R2
		Alerting (Network)	SolarWinds Orion	11.0.1	N/A
		Network Access Control	Cisco NAC 34xx, Cisco ISE	4.9.4, 1.3	N/A
		Intrusion Prevention System	Cisco Firepower, Palo Alto 50xx, Fireye	5.3.0.1, 6.0.8, 7.5.1	N/A
		Email Filtering (Spam)	Cisco IronPort	Cisco	N/A
		Web Filtering	BlueCoat 99xx	6.5.4.4	N/A
		Load Balancing	Cisco ACE 4710, F5 BigIP	A3(2.6), 11.6.0	N/A
		WAN Optimization	Riverbed Steelhead	8.0.4	N/A
		Data Loss Prevention	Symantec DLP	12.01	N/A
		AutoSys	VMWare ESX – Cisco UCS / IBM Power 795	Windows / AIX 7.1	Oracle 11g EE

WellCare Key Production Subsystems Hardware and System Architecture Specifications					
Key Platform	**Key Functions**	**Enterprise Application**	**Hardware Platform**	**OS Platform**	**Database Platform**
		Incident Monitoring	VMWare ESX – Cisco UCS	RHEL 5	MS SQL 2008 R2
		Symantec Endpoint Protection	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2008 R2

SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

102. Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the MCO's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the MCO's internal membership records, including differences in members' addresses. (*Page limit 3 pages)*

HIPAA COMPLIANCE MANAGEMENT

WellCare is fully compliant with the requirements of the 1996 Health Insurance Portability and Accountability Act (HIPAA) Title II Act-Administrative Simplification Standards including the applicable portions of 45 CFR 160, 162, and 164. We will take a proactive approach to meeting the standards for MLTC as outlined in *Section R.2 Systems and Technical Requirements, HIPAA Standards and Code Sets* of the RFP, as they relate to information exchange and the controls needed to ensure adequate system access management and information accessibility. We are currently in compliance with these requirements and will monitor these standards to ensure timely implementation of any changes.

Our Chief Compliance Officer oversees the implementation of and compliance with all current and future HIPAA standards. We actively promote compliance with the requirements of this section through multiple ongoing activities including:

- Maintaining policies and procedures describing the types of information to be safeguarded and the proper release of protected health information (PHI). These policies, including HIPAA Privacy, HIPAA Transactions and Information Security Policies, define and document our commitment to understanding and enforcing these standards.
- Creating and requiring the completion of annual training on Security, Privacy, Fraud Waste and Abuse, and HIPAA compliance by all associates and subcontractors is a condition of continued employment. All new hires are also required to complete this training within their first 30 days of hire. The administration and completion of this training is independently executed by our corporate training department.
- Associates also attend mandatory general compliance training designed to instill our core values and ethics. We maintain corporate policies that address system access management and information accessibility at the corporate level. In addition to the aforementioned programs, our Information Security Council meets regularly with key leaders to communicate and govern the information security risks throughout the organization.

Our electronic email encryption software for HIPAA security purposes will be compatible with that used by the state of Nebraska.

HIPAA Standards for Information Exchange

WellCare complies with the transaction standards rule 45 CFR Part 162 [CMS-0009-F] published on January 16, 2009. This rule mandates the use of the Accredited Standards Committee X12 (X12) version 5010 for health care, supporting the X12 version 5010 for health care transaction standards in the following table (**Figure 6**):

Figure 6

HEALTH CARE TRANSACTION STANDARDS	
➢ Claims and Encounters ▪ 837P – Professional ▪ 837I – Institutional	➢ Claims Status ▪ 276 – Claims Status Inquiry ▪ 277 – Claims Status Response

HEALTH CARE TRANSACTION STANDARDS	
▪ 837D – Dental ▪ NCPDP D.0 Pharmacy Claims	▪ 277U – Unsolicited Claims Status
➢ Remittance Advice ▪ 835 Remittance	➢ Premium ▪ 820 – Premium Payment
➢ Eligibility Inquiry and Response ▪ 270 – Eligibility Inquiry ▪ 271 – Eligibility Response	➢ Transaction ▪ 997 – Functional Acknowledgement ▪ 999 – Implementation Acknowledgement
➢ Enrollment ▪ 834 Benefit Enrollment and Maintenance	➢ Authorization Requests ▪ 278 Authorization Request

We use the Edifecs XEngine application to apply the appropriate 5010 Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) edits, inclusive of Level 1 through Level 7 edits, to all inbound and outbound transactions using the formats in the Health Care Transactions Standards table (above).

HIPAA Standards for Identifiers

WellCare captures and validates National Provider Identifier (NPI) information about providers against the National Plan and Provider Enumeration System (NPPES), a database of registered providers who have an NPI. This information is downloaded from the CMS website on a monthly basis. All providers to whom payments are made, and are not considered Atypical providers, are required to have an NPI to be credentialed or established as a provider. WellCare captures the NPI as part of the data about providers in its system of record. Other identifiers outlined in 45 CFR 160, 162, and 164 are not yet finalized or implemented, including the National Health Plan Identifier. We continue to monitor the status of CMS documentation and guidance, and we have reviewed the impact and changes required to implement the current draft requirements. These requirements are included in our 2016 Capital Plan approved funding.

HIPAA Standards for Information Exchange (Code Sets)

Our systems adhere to the standard code sets using a documented set of policies and procedures. Through a coordinated effort across our Compliance, Regulatory Affairs, Operations and IT organizations, updates to the standard code sets are identified in a timely manner and loaded into our systems. Our systems then use these standard code sets (**Figure 7**) for operational processing.

Figure 7

STANDARD CODE SETS	
Logical Observation Identifier Names & Codes (LOINC)	National Drug Code (NDC)
Health Care Financing Administration Common Procedural Coding System (HCPCS)	National Council for Prescription Drug Programs (NCPDP)
Current Procedural Terminology (CPT) Codes	International Classification of Diseases (ICD-9. ICD-10)
Diagnosis Related Group (DRG)	American Dental Association Current Dental Terminology (CDT-4)
Claim Adjustment Reason Codes	CMS HIPAA Remittance Remarks Codes
Home Infusion EDI Coalition (HEIC) Product Codes	National Correct Coding Initiative (NCCI) Codes

System Access Management

Protecting the security of members' confidential information is one of the guiding principles of

WellCare's Information Technology (IT) function. Our sophisticated, multi-layered approach to access and security provides a safe, stable environment for members' PHI. Our Information Security Policy requires all information systems to operate within the legal, contractual and regulatory requirements that affect WellCare, including but not limited to HIPAA, HITECH, Sarbanes Oxley, Payment Card Industry Data Security Standard (PCI-DSS), and the various state security and privacy requirements.

All system and application access is controlled via least rights, role-based security including hierarchical access levels as described in *R.9a-b Systems and Technical Requirements, Information Security and Access Management* of the RFP. Management determines authority levels for each role. The use of role-based security restricts access to information on a "need to know, least privilege" basis based on the individual user's profile. These hierarchical roles limit users to inquiry privileges only for all functions and activities where their role does not include the management, maintenance, or recording of transactions and data. Where data extracts, government partner portal or other reporting mechanisms (which also apply these security concepts) are not sufficient to meet access needs, WellCare can collaborate with MLTC and other Federal and State agencies to grant access from appropriate locations for an appropriate duration of time. All access to WellCare's infrastructure through external connectivity requires two-factor authentication, currently implemented using the Symantec VIP solution.

Member Eligibility File Reconciliation

Our Enrollment Eligibility System (EES) is designed to receive, process and update enrollment data daily (as discussed in detail in Question 104). The system uses the transmitted information through 834 files including monthly roster and termination files. The EES application tracks and reconciles each individual transaction from receipt through membership update. Each transaction received on the 834 files is compared to our Core Processing System (CPS) member tables. The information is generated and executed, ensuring that our member information accurately reflects active membership. Our member data is also reconciled on a monthly basis with capitation payment reports to ensure that payments (by rate cell) tie to our membership records.

WellCare's EES application supports the maintenance of multiple address-type records, including the original information submitted by the State or its enrollment broker. Using the data in the EES system WellCare will report member and phone number changes and identify the differences between member-reported data and MLTC data. WellCare members and users will be able to update separate home and mailing address types for delivery of correspondence and HIPAA validation. In other markets, WellCare has submitted monthly member data conflict reports. These reports include data conflicts that may affect a member's eligibility, including but not limited to name changes, date of birth, duplicate records, social security number or gender. WellCare also designates staff to coordinate with the Enrollment and Revenue Reconciliation teams to communicate all membership discrepancy types (including name, out-of-service-area address, date of birth, category of eligibility, cap payments, etc).

SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

103. Describe the MCO's approach to monitoring system availability issues and the resolution process. Provide a description of the MCO's system help desk. Include the MCO's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to MCO management within one business day of recognition and are promptly corrected. *(Page limit 2 pages)*

APPROACH TO MONITORING ISSUES AND RESOLUTION

WellCare's mature set of IT operations procedures and technologies are designed to monitor and resolve system issues in compliance with Service Level Agreements (SLAs) established with WellCare system owners and key external stakeholders (e.g. CMS, state Medicaid agencies). We maintain a formal System Problem Resolution Plan and Escalation Procedure that applies to all WellCare IT systems and services and meets the requirements as outlined in *Section R System and Technical Requirements* of the RFP. It is designed to handle all production incidents other than disaster scenarios and includes proper escalation steps should an incident evolve into a disaster scenario. The main objectives of our plan are to:

- Identify, record and classify service requests and incidents, and assign a priority according to business criticality and service agreements
- Identify and record incident symptoms, determine possible causes and allocate for resolution
- Document, apply and test the identified solutions or workarounds and perform recovery actions to restore the IT-related service
- Verify satisfactory incident resolution and/or request fulfilment and close
- Analyze root cause and implement appropriate changes to mitigate future occurrences of the issue

WellCare uses a combination of automated monitoring and operations tools as well as Infrastructure and IT Operations staff. They support a dedicated help desk accountable for the continuous monitoring of system performance, identification and troubleshooting of system issues, monitoring data exchange activities, coordinating corrective actions for failed records or transactions, and supporting internal and external systems users and IT staff.

System Availability Performance

Through October 20, 2015, we reported the following availability metrics for the year*:

- Overall System availability: 99.92%
- Claims Processing System (Xcelys) 99.95%
- Member/Provider service application (CAREConnects): 99.87%
- Website: 99.52%

*Additional metrics are tracked. These are a subset.

The ultimate objective of WellCare's stable architecture, redundant infrastructure and problem management procedures is to ensure our ability to meet the SLAs identified in RFP *Section R.10*. This includes continuous availability of confirmation of MCO enrollment (CME) electronic claims management (ECM), and self-service member and provider services functions, data transfers with all organizations and partners including MLTC, and internal systems outside scheduled maintenance periods. Upon discovering a system issue flagged from an automated internal alert, the user initiates a service desk ticket, and the severity of the issue is assessed immediately.

- Level 1 (system outage with targeted resolution within 8 hours) tickets immediately initiate a response and resolution process. The rapid resolution process involves using conference bridges with

relevant expertise (SWAT calls) to continuously work on issues until resolution. Email updates are sent to all impacted users as well as IT Management every hour until the issue is resolved.

- Level 1 and Level 2 (significant business impact) tickets require a complete root cause analysis review to define the reason for the incident and methods of preventing any reoccurrence.
- Level 2, Level 3 (limited impact) and Level 4 (enhancement) tickets are reviewed and associated changes are prioritized accordingly.

System Help Desk

We have automated monitoring and alerts on all production systems. Additionally, WellCare's IT Operations staff members monitor production systems (including transfer of files to/from states) with continuous on-site support 24 hours per day, 7 days per week. Our end user help desk is staffed Monday to Saturday from 7:00 am to 7:00 pm central time. Immediate, on call support is available for any critical or urgent issue occurring outside of regular hours.

WellCare's end user help desk is staffed Monday through Friday from 6:00 am to 8:00 pm central time to log, support and serve as a point of contact for resolution of IT issues reported by WellCare associates. Our state partners can submit a help desk request via a 24x7 partner portal application or by contacting their Point of Contact within WellCare who can contact the help desk via multiple methods including toll-free phone, email or by logging into the help desk ticketing system. For issues submitted between 8:00 pm to 6:00 am, the help desk will respond by 9:00 am the next day. If the issue is urgent (e.g. there appears to be no connectivity to WellCare systems), the state's Point of Contact can call an on-call number, and they will receive a response within 30 minutes. All issues, requests and incidents are recorded and tracked in WellCare's Computer Associates (CA) Information Technology Service Management (ITSM) application. CA's ITSM provides email notification to the submitting user whenever updates are made to the ticket. For example, users will receive a notice that a technician has resolved the issue. If the issue is email-related, the help desk will contact the user via phone.

Notification Procedures

The Information Management and Systems Director, identified as key personnel in the RFP, will serve as the primary liaison to the MLTC for all IT activities. This individual will receive automated notifications and communications from help desk and command center staff. Communication accountabilities for this role will include:

- Notification of any disaster scenarios, including recovery status within 72 hours
- Notification within 60 minutes of any system issues affecting data exchanges with MLTC
- Notification within 15 minutes of any report distribution delays or outages of either online or critical system functions
- Hourly updates to MLTC on the status and resolution progress for outage events
- Providing MLTC written documentation of availability events including root cause research and any necessary corrective actions

Escalation Procedure

If a state partner believes an issue is not being addressed in a satisfactory manner, they can reach out to their Point of Contact within WellCare, who will initially escalate the issue with WellCare's Problem Management team, and if necessary, WellCare's Vice-President of Infrastructure.

SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

104. Provide a description of the MCO's eligibility and enrollment database. Include a description of how the MCO will:

- Complete updates within the timeframes specified in the contract.
- Identify members across multiple populations and systems.
- Monitor, track, and resolve any discrepancies between the enrollment files and the MCO's system (e.g., duplication of records and information mismatches).

(Page limit 2 pages)

ELIGIBILITY AND ENROLLMENT DATABASE

WellCare's Enrollment and Eligibility System (EES) as depicted in **Figure 8** on the following page is able to process daily 834 enrollment files within 24 hours of receipt as specified in *Section R.5 Systems and Technical Requirements, Eligibility and Enrollment Data Exchange*. EES is used to receive, process and update enrollment data daily using the information transmitted by the State through 834 files delivered on the frequency specified by the State, including monthly roster and termination files.

Updating within the timeframes

The EES application tracks and reconciles each individual transaction from receipt through membership update. Our member eligibility processes recognize the State as the source of truth for member eligibility history (with beginning and ending dates) and demographic data, such as name and date of birth, including storing and tracking all data by the state Medicaid ID. As a result, each transaction received on the 834 file is compared to our Core Processing System (CPS) member tables. Updated transactions needed to align our member tables with the information provided are generated and executed, ensuring that member information accurately reflects active membership, within the 24 hours service level agreement as specified in the RFP. A complete history of eligibility information is maintained for each member including effective and termination dates.

By the Numbers: Excellence in Action

In 2014, we processed an average of 8.4 million Medicaid 834 transactions per month.

Identifying Members across Multiple Populations

During the processing of the 834 file from the State's enrollment broker, WellCare will utilize the associated rating factors, categories and demographic information such as county when appropriate, and map each eligibility to a Benefit Plan Code. This benefit plan code is unique to each population and allows WellCare to clearly define the benefits and services members are entitled to.

Identifying Members across Multiple Systems

An advantage of WellCare's single-instance application architecture is that all WellCare platforms utilize the same unique identifier for a member. All delegated vendors, such as pharmacy benefit manager (PBM)s are required to use this number (and the associated Benefit Plan Codes) as well. This approach eliminates the potential for mapping and translation issues aross platforms and vendors.

Monitoring and Resolving Discrepancies

WellCare's EES application supports multiple edits and validation on the incoming 834 data during the processing stages. In addition, we reconcile the 820 payment files and its membership records on a monthly basis. As a result of these processes, WellCare has been able to identify duplicate records and

report this information to other State agencies.

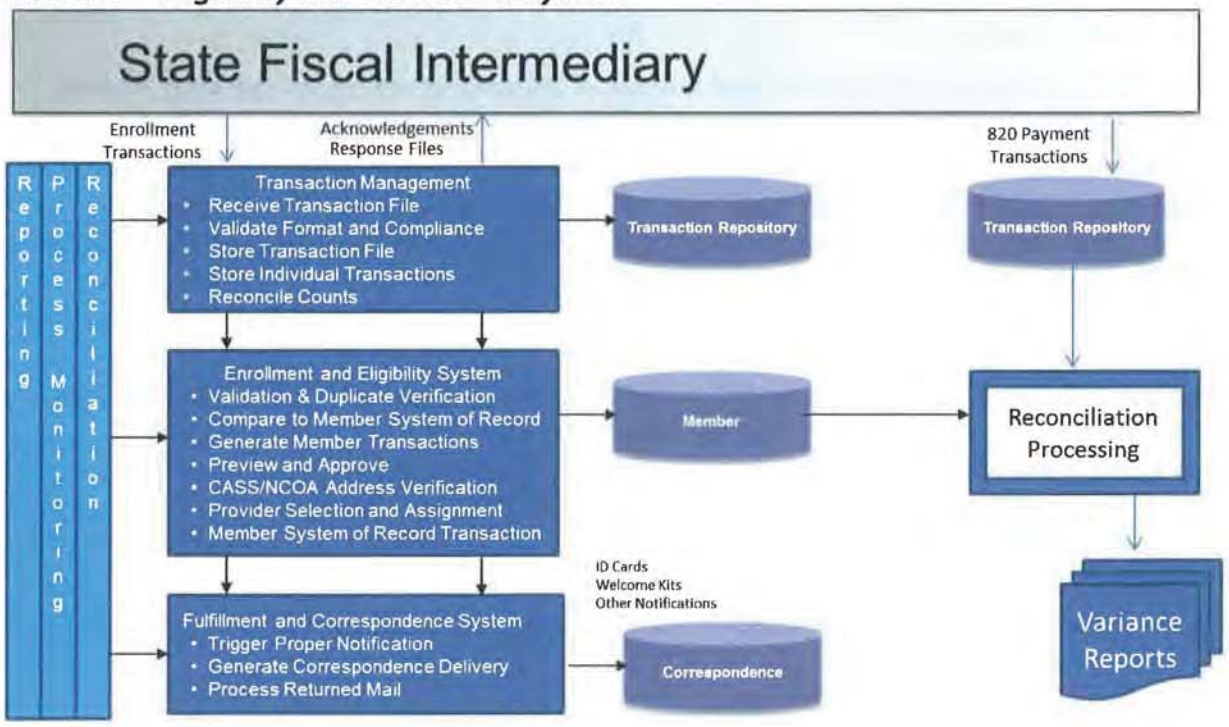
WellCare will submit monthly Member Data Conflict Reports. These reports include data conflicts that may affect members' eligibility for MLTC including but not limited to name changes, date of birth, duplicate records, social security number or gender.We will designate staff to coordinate with the Enrollment and Revenue Reconciliation teams to communicate all membership discrepancy types (including name, out-of-service-area address, date of birth, category of eligibility, cap payments, etc.).

Reporting Address Changes

WellCare's EES application supports the maintenance of multiple address-type records, including the original information submitted by the State or its enrollment broker. Using the data in the EES system WellCare can report member address and phone number changes and identify the differences between member-reported data and the State data.

Figure 8

WellCare – Eligibility and Enrollment System



SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

105. Provide a description of the MCO's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities. *(Page limit 3 pages)*

INFORMATION SECURITY MANAGEMENT

Information Security is of paramount important to us; therefore, we have instituted an Information Security department. The Information Security department reviews all relevant guidance and ensures compliance as it works with the IT department. The head of Information Security reports directly to our Compliance Officer. Most of our Security and Privacy policies and procedures enterprise-wide are actually authored by the Information Security department, including for topics such as records retention. The purpose of this department is to manage privacy and security in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as modified by the Health Information Technology for Economic and Clinical Health (HITECH) Act set forth by the United States Department of Health and Human Services (HHS).

To provide additional oversight for this vital function of information security management, we have established an Information Security and Privacy Officer whose major responsibilities include:

- Development, implementation and management of WellCare's Information Security, Privacy, and Records and Information Management (RIM) Compliance Program and governance process
- Oversight of development and monitoring of Information Security, Privacy and RIM compliance policies and procedures
- Development and monitoring of Information Security, Privacy and RIM compliance education and training programs
- Development and implementation of effective lines of Information Security, Privacy and RIM Compliance Program communications and reporting mechanisms
- Development and implementation of appropriate oversight committees and/or procedures to enforce sanctions and disciplinary actions for violations of Information Security, Privacy and RIM regulations or policies
- Monitoring and auditing for ongoing compliance including risk assessments and penetration testing
- Investigation of reported and detected non-compliance incidents and development of corrective action initiatives

WellCare's Information Security policies include, but are not limited to:

- Antivirus, antispam and malware policies
- Malicious code incident prevention
- Computer security incident management, incident response and incident reporting
- Appropriate use and monitoring, appropriate use of information technology resources, electronic communications accountability and privacy in the workplace
- A corporate Risk Management Program that monitors, assesses and reviews information technology (IT) and security on an annual basis
- Mandatory security awareness training for our employees within 30 days of recruitment and annually thereafter
- A Disaster Recovery and Business Continuity Plan based on a Business Impact Assessment (BIA)
- A password policy that incorporates the requirements for password implementation (including Strong

Password Use, Password Authentication, and Third-Party Security Requirements) for access to all systems and external parties

Access Restrictions

As described in *R.9a-b Information Security and Access Management* of the SOW, the use of role-based security restricts access to information on a "need to know, least privilege" basis based on the individual user's profile. These hierarchical roles limit users to inquiry privileges only for functions and activities where their role does not include the management, maintenance, or recording of transactions and data. Management determines authority levels for each role. Regulatory report, data extracts and the government partner portal access functions are WellCare's primary method of supporting transparency and MLTC's access to date. Where these mechanisms (which also apply these security concepts) are not sufficient to meet access needs, WellCare will collaborate with MLTC and other federal and state agencies to grant appropriate access from appropriate locations for an appropriate duration of time. All access to WellCare's infrastructure through external connectivity requires two-factor authentication, currently implemented using the Symantec VIP solution.

Managing Information Integrity

As mentioned above, WellCare's Information Security officer is responsible for monitoring and auditing for ongoing compliance including risk assessments and penetration testing. Our servers, workstations and networking systems are continuously monitored using industry-standard intrusion protection technologies. WellCare also leverages a 3rd party firm that specializes in information security to conduct a comprehensive penetration test once a year. Results of the tests are reviewed by IT infrastructure management and by the Information Security team, and changes are made accordingly.

WellCare's multiple technical solutions support the management of information integrity, including

- The implementation of the Health Information Trust Alliance (HITRUST) Common Security Framework (CSF) across all aspects of IT applications and operations
- The use of secure FTP sites for the transfer of files (PHI data in Transmission) with any submitting or receiving entity. WellCare supports privacy and encryption using SSH certificates or username/password, SSL, and, as an alternative, PGP encryption
- The use of HTTPS along with required login and password verification for members and providers prior to display and access to PHI on our web portals
- The implementation of security controls including; storage-level encryption for portable data storage, Network Access Control, Intrusion Detection, advanced persistent threat protection, web proxies and other solutions to protect PHI data at rest.

The table below (**Figure 9**) shows the specific technologies leveraged by WellCare.

Figure 9

Infrastructure and Security	➢ Firewall ➢ Alerting ➢ Virus Scanning ➢ Core Switches ➢ Scheduler ➢ Network Access Control ➢ Intrusion Prevention	Firewall	Cisco ASA 55xx-X, Palo Alto 50xx	ASA 9.2,6.0.8	N/A
		Core Switches	Cisco Nexus 7010	NXOS 5.2(9)	N/A
		SCOM	VMWare ESX – Cisco UCS Blades	Windows 2008/2012	MS SQL 2008 R2
		Alerting (Network)	SolarWinds Orion	11.0.1	N/A
		Network Access	Cisco NAC	4.9.4, 1.3	N/A

	(IPS) - Web & Spam Filtering - Incident Monitoring - Antivirus and Malware	Control	34xx, Cisco ISE		
		Intrusion Prevention System	Cisco Firepower, Palo Alto 50xx, Fireye	5.3.0.1, 6.0.8,7.5.1	N/A
		Email Filtering (Spam)	Cisco IronPort	Cisco	N/A
		Web Filtering	BlueCoat 99xx	6.5.4.4	N/A
		Load Balancing	Cisco ACE 4710, F5 BigIP	A3(2.6), 11.6.0	N/A
		WAN Optimization	Riverbed Steelhead	8.0.4	N/A
		Data Loss Prevention	Symantec DLP	12.01	N/A
		AutoSys	VMWare ESX – Cisco UCS/IBM Power 795	Windows/AIX 7.1	Oracle 11g EE
		Incident Monitoring	VMWare ESX – Cisco UCS	RHEL 5	MS SQL 2008 R2

Managing Audit trails

WellCare's application architecture builds into the base applications comprehensive, automated edits and audits to ensure that all data is valid, whether received from external sources or entered directly into our applications. All processes that integrate data from external sources create a unique tracking number for each incoming transaction to support end-to-end balancing and reconciliation. All errors are tracked (and reportable by type, frequency, source and other critical factors), and audit trails are maintained throughout the process to allow for the reconstruction of processing events. Applications that support direct data entry validate the information as it is input. Applications track and reconcile each individual transaction including the account that made the change from receipt, through membership update, including the user or process that created or modified the information. Data, specifically financial transactions, that have been executed, which are considered "final" require separate transactions and are not able to be updated.

Physical safeguards

WellCare's data processing facility is managed by a tier 1 data center vendor, CenturyLink. The facility includes fire and flood sensors as well as a robust fire suppression system. Physical security measures include access cards, biometric devices and a man trap as an anti-tailgating measure in the data center lobby. All equipment is physically secured within locked cages with dedicated intra cage video surveillance. More details about CenturyLink's capabilities can be found at http://www.centurylink.com/business/enterprise/resources/products/tp1-tampa-fl.html.

All corporate and remote WellCare staffing locations require company issued employee badges to gain access to the facilities. Any network or computer equipment locations are isolated and are further restricted to authorized individuals. All locations include appropriate monitoring, alarm and arresting capabilities for electrical, smoke and fire conditions.

SECTION IV.R SYSTEMS AND TECHNICAL REQUIREMENTS

106. Describe the MCO's business continuity, contingency, and recovery planning. Attach a copy of the MCO's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery:

1. Operational and system redundancy in place to reduce the risk of down-time.
2. System and operational back-up sites.
3. Contingency and recovery planning including resumption of operations.
4. Prioritized business functions for resumption of operations and responsible key personnel.
5. Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable.
6. Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith.
7. Testing approach and regular schedule to improve and update the plan over time.

(Page limit 3 pages, excluding sample plan)

BUSINESS CONTINUITY, CONTINGENCY AND RECOVERY PLANNING

WellCare has infrastructure and business operations designed to continuously support our members and providers and ensure system availability with minimal disruption of services at all times, regardless of extraordinary events. Our business continuity, emergency preparedness and disaster recovery plans address events outside of our control. We test these plans regularly both at the corporate and local level. The plans are updated at least annually, and we collaborate with our government partners as needed. These plans, coupled with WellCare's robust infrastructure, ensure system availability with minimal disruption of services at all times regardless of extraordinary events.

WellCare's Focus on Excellence

During the 2015 DR test, all 15 core systems tested were recovered successfully and approximately 50% faster than the required recovery time objectives.

Attached are WellCare's comprehensive Emergency Preparedness Plan, Disaster Recovery Plan (DRP) and Business Continuity Plan (BCP), which addresses both infrastructure and business operations and meets the requirements outlined in *Sections R.10 through R.12* of the RFP. **(Attachment 106a_Business Continuity Plan, Attachment 106b_Disaster Recovery Plan, Attachment 106c_ Emergency Preparedness Plan)**

The BCP and DRP address events including, but not limited to the following:

- Extended power outage
- Extended network outage (LAN/WAN)
- Severe data corruption
- Security threats
- Environmental disruptions
- Localized disasters

Operational and System Stability – Reducing the Risk of Down-Time

WellCare's operations, infrastructure and communications environments provide multiple levels of preventive measures to ensure system availability, data integrity and business continuity like: (1) WellCare's use of a Class 1 secure data center with built in power and communications redundancy is the starting point for our enterprise system architecture. (2) We also implement redundancy in power and communications to critical processing and operations locations including Uninterruptable Power Supplies and Diesel generators. (3) Our use of virtualization for application and infrastructure components, along with the installation of redundancy in hardware and communications components, contributes to

significant reduction of risk due to outages.

System and Operational Back-Up Sites

WellCare routinely completes incremental backups and weekly full backups of applications and systems. These tape backups are stored at a secure off-site vendor location (currently contracted through Iron Mountain) external to any WellCare data center or office location. WellCare's Data Center recovery site is contracted through SunGuard Availability Services and is located in Secaucus, NJ. If needed, WellCare's operations will leverage and move to its multiple office locations across the United States.

Contingency and Recovery Planning

In the event of catastrophic system failure, our Data Center Recovery plan is initiated to protect our data and transactions. The execution of this plan provides restoration of applications and data and, as a result of the multiple connectivity options, allows for the resumption of normal business operations. If we experienced a system interruption or isolated failure, the system would automatically fail over to redundant equipment or IT would roll back the application to a prior recovery point. In the event of an emergency, WellCare would leverage all corporate resources for communication and business continuity, such as work load shifting to other WellCare locations, including corporate. Every department at WellCare has a detailed Business Continuity Plan (BCP) to ensure continuity of services to our members and providers (i.e. Customer Service, Claims, Pharmacy, Care Management, Enrollment, etc.)

Prioritized Business Functions: WellCare's DRP identify operations and infrastructure capabilities by Tier, defining the priority and sequence of recovery.

- **Tier 0 – Foundational**: Basic Infrastructure components (Telephones, Desktop Apps, Email, Wellcare.com, etc.)
- **Tier 1 – Mission Critical:** Ability to support critical interactions with members and providers and support for receiving transactions from external parties (Claims, UM, DM, CM, Customer Service). Includes components to recover Tier 2 Applications.
- **Tier 2 – Critical:** Full processing capabilities of critical, time-sensitive business functions including Claims, Grievances & Appeals, Enrollment. Include components to recover Tier 3 Applications.
- **Tier 3 – Important:** Establishes capability to resume operations and availability of all enterprise capabilities, meet any regulatory commitment with <72 hour obligations.
- **Tier 4 – Non-critical:** Remaining departmental, non-time-sensitive or non-critical applications.

Identified key personnel

We will identify key personnel to ensure business continuity and a quick recovery of the Business Unit. The attached BCP provides an example of the Georgia Business Unit Recovery Team. We would develop a similar team for Nebraska; these associates would be the first responders and responsible for the execution of any recovery activities for Nebraska.

Employee and Supplier Preparedness

All WellCare associates are provided Emergency Preparedness Training upon hire and at least annually thereafter. The training focuses on ensuring associates safety and the protection of and continuity of care for our members during a disaster. Our associate training emphasizes the protection of **"Three Ps"** when responding to any emergency: **People, PHI (Protected Health Information) and Production.**

Communication to Employees and Suppliers

Each department has detailed business continuity plans that address communications with suppliers in the event of an emergency as well as identifying the Business Unit Recovery Team and their roles and responsibilities during an emergency situation. In case of any safety incidents within our offices or work sites, our associates are notified by a safety coordinator or by alarms within the building. When a safety

incident becomes an emergency, or a natural disaster occurs, there are several different ways that associates can gather information, including the Emergency Hotline: 1-866-473-9135, WellCare Link myHR Portal/HR Service Center (https://portal.adp.com), emails, call trees, and the SmartNotice Emergency Notification System, which is used to communicate emergency information to associates through the use of their personal and WellCare phone(s) and email(s).

Provider Preparedness – We Ensure Continuity of Care

WellCare providers are updated before, during and after an event via the WellCare website(s) and normal channels of communications. In the event of an emergency, WellCare would leverage all corporate resources for communication and business continuity, such as work load shifting to other WellCare locations, including Corporate.

Community Engagement Strategies

In addition to ensuring the safety and wellbeing of our members, their families and our employees, WellCare designed a community-focused strategy that works in parallel with the American Red Cross. WellCare sponsored the American Red Cross to conduct "Ready When the Time Comes" emergency response training for 45 WellCare associates from across the company.

Being there in times of Need: WellCare Disaster Response

In February 2013, WellCare responded to a tornado that touched down in Adairsville, Georgia using its three-point community approach. While no members were injured, WellCare of Georgia worked closely with the locally deployed team of the American Red Cross to assist in the impacted community. Through this effort, WellCare invested more than 200 volunteer hours to assist in the recovery of residents in Adairsville including representatives from several different departments like case management, provider relations and so on.

Testing Approach

We employ two strategies to test our Corporate EPP:

- Annual table-top exercises are used to evaluate plans and identify possible gaps for remediation
- Annual systems recovery testing before the start of the Atlantic hurricane season

Improving and updating the plan

Our 2015 system recovery test was completed during the week of February 16, 2015. Testing results are documented and presented to the EPC and the EP Steering Committee. In addition, our Internal Audit department audits the annual testing process and has not noted any significant issues. On an ongoing basis, and specifically after each test execution, WellCare examines its BCP and DRP for opportunities to implement improvements and to identify needed capital investments for inclusion in future budgets. Our IT and EPC teams will use these test results to further refine and improve data center recovery capabilities.

Proprietary and Confidential Information

WellCare

Business Continuity Plan

22 Pages

Proprietary and Confidential Information

WellCare

Information Technology Disaster Recovery Plan (ITDRP)

51 Pages

Corporate

WellCare Corporate Emergency Preparedness Plan

2015

V 5.1

PREPARED BY

EMERGENCY PREPAREDNESS COMMITTEE

COMPREHENSIVE HEALTH MANAGEMENT, INC.

Revision History

Revision	Release Date	Author	Changes in progress
0.01	11/25/2008	W. Greg Brooks	Working Copy – created from individual functional area business continuity documents
0.02	11/25/2008	W. Greg Brooks	Complete Draft Document Framework prior to functional area review
0.03	1/13/2009	W. Greg Brooks	Added Regulatory Reference Table
0.04	3/30/2009	Denise Malecki	Combined revised Corporate BCP with sections written for a proposed Corporate DRP
0.05	10/5/2009	W. Greg Brooks	Refreshed document for 2009
1.0	5/26/2010	William McKinney	Reworked entire document.
1.2	7/28/2010	William McKinney	Updated EPC membership in Appendix C to reflect changes in sales and marketing and pharmacy EPC membership.
1.3	9/30/2010	William McKinney	Updated EPC membership in Appendix C. Added additional beneficiary and pandemic content. Updated training requirements. Removed Mike Cotton from steering team list. Added new approvals.
1.4	10/22/2010	Steven Tate	Updated EPC membership in Appendix C. Updated Steering Team in App D (removed Rex Adams, added Larry Anderson, and changed Walt Cooper title and role).
2.0	4/28/11	Steven Tate	Updated for 2011, including: addition of EPC Charter ratified 1/21/11; allowance of EPP approval by functional VP or Area Leader; embedded PDFs of approved Corp EPP and EPC charter.
2.1	8/1/11	Steven Tate	Updated appendix: steering team, EPC representatives, and emergency planning location 1.

Revision	Release Date	Author	Changes in progress
2.2	11/23/11	Steven Tate	Updated appendix and TOC: EPC representatives; added state RA contacts.
3.0	1/27/12	Steven Tate	Updated appendix and TOC: EPC representatives; received Exec Sponsor sign-off on 2012 version.
3.1	5/22/2012	Steven Tate	Updated appendix and TOC: EPC representatives, Steering Team, RA contacts; added glossary from Area EPP template; update section 2.2.
3.2	7/11/2012	Steven Tate	Updated Appendix C (EPC Representatives) and refreshed date on Appendix B (Steering Team).
3.3	8/23/2012	Steven Tate	Updated Appendix C (EPC Representatives).
3.4	4/30/2013	Frederick Trathen	Updated Glossary; Updated EPC notification criteria; Updated Appendix: B - EP Steering Team Membership, C - EPC Membership D - Emergency Preparedness Contractual Requirements E - EPC Meeting Locations F - WellCare Regulatory Affairs Associates.
4.0	3/24/2014	Brien Burkett	Reworked entire document.
4.1	11/21/14	Staci Cross	Updated Emergency Declaration Map, Associate Communications, Member & Provider Communications
5.0	12/9/14	Staci Cross	Updates to support RFP request. Correction of inconsistencies.
5.1	9/28/15	Danielle Hancock	Updated naming inconsistencies, Visio

Approvals

The management team members identified below have reviewed this emergency preparedness plan and agree that the boundaries and activities identified in this document are accurate to the best of their knowledge.

Name	Title	Signature	Date
Staci Cross	EP Lead		12/9/14
Mike Polen	SVP, Operations		12/9/14

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PURPOSE

The purpose of the Corporate Emergency Preparedness Plan is to ensure WellCare Health Plans, Inc. is prepared to provide services to our members and providers in an emergency situation. Processes and procedures have been developed to support both business continuity as well as disaster recovery to restore full operations after an event. This WellCare Corporate Emergency Preparedness Plan (EPP) provides the strategic Corporate Business Continuity Plan (BCP) and Disaster Recovery Plan (DRP) for WellCare Health Plans, Inc., herein referred to as "WellCare".

The BCP facets of this plan identify WellCare's strategic capabilities for ensuring the continuity of member and provider services in response to an emergency event. The DRP portion of this plan is designed to provide immediate response and subsequent recovery from an emergency event. An emergency event is an unplanned business interruption, man-made or natural, including but not limited to inclement weather, declared emergencies, systems failures/disruption, loss of utility services, building evacuations, fire, etc.

The combination of the BCP and the DRP shall be herein referred to as an Emergency Preparedness Plan (EPP).

WellCare's priorities and primary objectives are:

- **People**: Ensure WellCare's associates have been trained on the proper response to emergency situations and are out of harm's way in the event of an emergency.
- **PHI** (Protected Health Information): Ensure WellCare has taken appropriate measures to protect PHI during emergency situations.
- **Production**: Ensure WellCare has steps in place to prioritize and continue production activities ensuring members have access to care.

WellCare believes that the priorities above are embodied within the Corporate EPP and appropriate to provide safety and well-being for WellCare associates while still providing prompt and appropriate responses to both anticipated and unanticipated emergency events.

1.1 Associated Plans and Subordination

This document governs WellCare's Corporate EPP and includes elements common across business functions. This document does not account for the entirety of WellCare's EPP. Instead, this document is a 'parent' document to accompany the business area EPPs. A business "area" generally consists of multiple departments and/or divisions reporting to a WellCare vice president or area leader. The business area EPPs contain detailed disaster recovery and business continuity plans for that business function.

The Corporate EPP makes every effort to be aligned with existing WellCare policies and procedures, contractual requirements, and federal, state, and local laws. In the case of any conflict, the Corporate EPP shall be considered subordinate to these other documents, requirements, and/or regulations.

In addition, the Corporate EPP is subordinate to Federal, state and/or local plans during a disaster declaration by those authorities. WellCare will cooperate with state, county and city emergency officials as well as other responders in the development of emergency response plans and participate in multi-jurisdictional emergency planning exercises as required.

1.2 EPP Scope and Assumptions

The scope of the Corporate EPP includes WellCare's corporate campus in Tampa and various field offices within the contiguous 48 states and Hawaii. The Corporate EPP shall be updated annually by the Emergency Preparedness Committee (EPC) to include new regions and plans that are added to the scope of WellCare's operations.

The scope of the Corporate EPP does not include business continuity or disaster recovery of WellCare's medical and administrative vendors. Review of emergency planning for such vendors shall be managed through pre-implementation and annual delegation audits in addition to other normal vendor management venues.

The scope of the Corporate EPP does not include WellCare's response to emergency situations and disaster declarations impacting WellCare's membership where such emergencies do not also impact one or more of WellCare's field offices or the corporate campus except as outlined in sections 1.3 and 1.4 below. Such emergency situations shall be handled as outlined in functional policies, procedures, and/or step actions.

The Corporate EPP is designed to create a state of readiness that will provide a structured response to both anticipated (e.g., storm closure) and unanticipated (e.g., immediate building evacuation) emergencies as well as other external incidents that potentially could cause business interruption (e.g., loss of electrical service).

The Corporate EPP is based upon the following assumptions. Additional assumptions present in the business area EPPs are outlined within those documents.

- Business recovery is performed in accordance with the procedures that have been set forth within this plan and subordinate documentation
- Plan review, maintenance and updates are performed on an annual basis by the EPC to ensure accuracy and a viable state of readiness
- Sufficient alternate sites that are pre-designated as backup facilities are unaffected and prepared to support recovery of business functions
- Organizations external to WellCare, such as customers, vendors, government agencies, and others will be reasonably cooperative during the business recovery period
- Business recovery awareness and training programs have been implemented and exercised annually
- Qualified personnel in sufficient quantities are available to perform business recovery responsibilities

- Adequate communication channels and contact information are available for executive decision making and associate communication
- Required funding, equipment, and supply requirements will be reviewed and approved in a timely manner

1.3 Beneficiary Emergencies

WellCare's corporate policies and procedures allow WellCare to respond to the increased volume of claims and beneficiary interactions associated with emergency situations. WellCare policies relax medical management requirements, such as prior authorization and prescription refill limitations, where necessary and appropriate.

In the event of a localized public health emergency, WellCare will work with the appropriate state and Federal agencies to conduct outreach in an attempt to contact members and determine which members may meet criteria for additional assistance with special medical needs and/or transportation. Where necessary and appropriate, WellCare will conduct claims reviews in an attempt to determine members with special needs during an emergency event.

1.4 Corporate Pandemic Disease Response

WellCare considers a pandemic to be an anticipated event for which some planning and preparation is likely. As such, much of the response to a pandemic would be handled using the Corporate EPP for anticipated emergencies.

During a pandemic, in addition to the normal responsibilities outlined in the Corporate EPP, the Fleet and Facilities Department will provide physical security and emergency support to affected areas. The Fleet and Facilities Department will coordinate all services for sanitization and health quality restoration. This group will make a prognosis for occupancy of each company facility affected by an outbreak. Additionally, Fleet and Facilities will coordinate risk reduction and avoidance activities as well as emergency response with property management and local emergency response authorities.

In the case of a mass vaccination campaign initiated by a state or Federal agency, WellCare will make its facilities available as requested and appropriate.

1.5 Emergency Preparedness Governance

WellCare's Emergency Preparedness Committee (EPC) is the governing body responsible for maintaining WellCare's Corporate EPP. The mission of WellCare's EPC is to provide the guidance and support that facilitates the development and implementation of all area EPPs. The EPC charter is included as Appendix A of this document.

The Emergency Preparedness Lead (EPL) shall preside over all meetings of the EPC at which he or she is present and shall act as the chief liaison between the EPC and the Emergency Preparedness Executive Sponsor (EPES) and the Emergency Preparedness Steering Committee (EPS). The EP Lead shall be responsible for maintaining the Corporate EPP, facilitating the activities of the EPC and its representatives, and otherwise serving as a central point of contact for WellCare's emergency preparedness and business continuity activities. The

EP Lead shall appoint a backup to preside over meetings when the Lead is unable to attend and otherwise act in the stead of the Lead as needed. The EP Lead may appoint an EPC secretary who shall give notice of all EPC meetings, prepare agendas, record and maintain and distribute minutes, and maintain the WellCare Emergency Preparedness SharePoint site.

Escalation from the EPC shall be via the EP Lead to the Emergency Preparedness Executive Sponsor. The EP Executive Sponsor provides guidance to the EP Lead and the EPC, as well as acts as the chief liaison to the EP Steering Committee. The EP Steering Committee is comprised of WellCare executive leadership and the EP Executive Sponsor serves as its Lead. The EP Steering Committee is responsible for declaring and managing an emergency situation.

The EPC shall convene at least quarterly to review the status of WellCare's emergency planning activities, report updates by area, and/or assign tasks necessary to improve WellCare's Corporate EPP. Additional EPC meetings shall be convened as necessary to review possible emergency situations and make the determination when/if to escalate situations for formal emergency declaration.

The EPC and EP Steering Committee members are maintained on the Emergency Preparedness SharePoint site at:

http://wellcareportal.wellcare.com/CorporateCompliance/EmergencyPreparedness/Pages/default.aspx

1.6 Approval and Distribution

The Corporate EPP is a confidential document maintained by the EP Lead and governed by the EPC. The business area EPPs are confidential documents maintained by the associated departments under the guidance of the EPC. The Corporate EPP and its components are available to all EPC and EPC members and are made available to WellCare associates on a "need to know" basis. Members of the EPC may access and maintain the Corporate EPP, business area EPPs and all associated documents on the Emergency Preparedness SharePoint site at:

http://wellcareportal.wellcare.com/CorporateCompliance/EmergencyPreparedness/Pages/default.aspx

The EP Lead is responsible for ensuring all EPP documentation is reviewed and updated annually. The EP Executive Sponsor and the EP Lead are responsible for updating and approving the Corporate EPP. The EPC Charter may be amended only after a two-thirds vote of the EPC membership followed by approval by the EP Lead and EP Executive Sponsor. All business area EPPs shall be reviewed and updated by the business area EPC representative and approved by the associated vice president or area leader as well as the EP Lead.

It shall be the responsibility of WellCare's various regulatory affairs personnel (state and CMS) to collect and submit appropriate, applicable portions of the Corporate EPP and associated WellCare policies and procedures upon request by state and Federal agencies. It is also the responsibility of these regulatory affairs personnel to provide the EP Lead with timely notification of document and information requests.

1.7 Contractual and Regulatory Compliance

WellCare is a nation-wide company servicing members in multiple states with health plans that must comply with the respective Federal and state regulatory requirements. Different governing agencies may have specific business continuity requirements which dictate the activities of WellCare. In all cases, WellCare's objective is to abide by all contractual and regulatory mandates and maintain service continuity and sustainability.

In addition to compliance with HIPAA contingency plan governing standards (Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Standards for the Protection of Electronic Protected Health Information; 45 CFR Part 160 and Part 164, subparts A and C), the primary universal requirement throughout WellCare's contracts is the prompt notification to CMS, state agencies, and other regulating bodies in the event of an emergency impacting WellCare's ability to perform services. Such notice shall be the responsibility of the corporate Compliance Department (CMS and other Federal agencies), Legal Department, and regional regulatory affairs departments (state agencies).

1.8 Associate Awareness and Training Activities

The EPC shall provide general emergency planning awareness training to all associates at least once per calendar year. Specific area EPP training shall be the responsibility of the area EPC representatives and provided to associates as appropriate.

1.9 Plan Testing

WellCare employs two strategies for testing of its Corporate EPP. First, annual table-top exercises are used to evaluate plans and identify possible gaps for remediation. In addition to the table-top exercises, WellCare shall conduct annual systems recovery testing prior to the start of the Atlantic hurricane season. The result of the testing shall be documented and presented to WellCare's Internal Audit Department, the EPC and the EP Steering Committee.

EMERGENCY DECLARATION

1.10 Identification, Assessment, and Activation

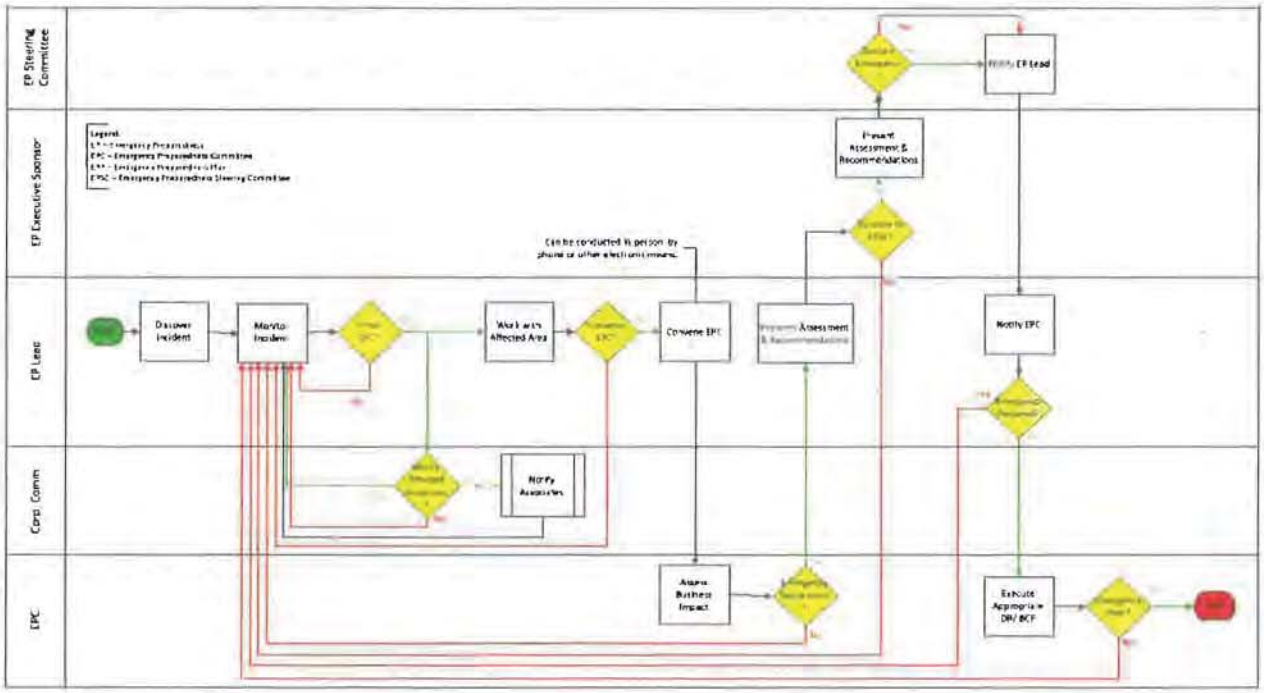
Upon discovery of a major incident that could potentially interrupt WellCare's business, the EP Lead alerts (and if necessary, convenes) the EPC and updates the EP Executive Sponsor as appropriate. Within four hours, the EPC assesses the incident's impact to business operations and develops recovery recommendation(s) as necessary. In the event the EPC recommends the declaration of an emergency, the EP Lead presents the assessment and recommendation to the EP Executive Sponsor for a decision regarding escalation to the EP Steering Committee and possible declaration of an emergency.

The EP Steering Committee shall be responsible for the declaration of an emergency and for making any associated decisions necessary before EPPs can be initiated. The EP Steering Committee includes the Senior Management Team and the CEO of WellCare Health Plans, Inc.

EP Steering Committee decisions shall be put to a simple majority vote of members present. The EP Executive Sponsor shall serve as the tie-breaker for any votes. Once convened by the

EP Executive Sponsor, the EP Steering Committee members present shall be deemed sufficient for all decision making even if the members present do not represent a quorum of the EP Steering Committee.

Once approved by the EP Steering Committee, the decision to declare an emergency is then communicated by the EP Lead to the EPC who then communicates to the appropriate business areas. Emergency response and business continuity activities go into effect immediately. Depending on the nature and scope of the emergency, the Corporate Communications team may also distribute one or more associate announcements and/or update the associate emergency hotline message.



Meetings of the EPC and / or EP Steering Committee may be conducted in person, via telephone, or via other electronic communication channels as necessary for timely communication and decision-making. The EP Lead shall be responsible for communicating the location and time of EPC and EP Steering Committee meetings in the event of an emergency. Emergency meeting locations and the conference bridge are identified in Appendix C of this document.

1.11 Associate Expectations

All associates, regardless of level, are responsible for checking the WellCare Emergency Hotline at (866) 473-9135 and returning to work when requested or immediately at the conclusion of the emergency.

All associates should check work voicemail twice daily during an emergency, call the WellCare Emergency Hotline twice daily during an emergency, and be available by phone in the event that supervisors or other WellCare personnel need to convey critical information. WellCare

associates also are expected to monitor local TV and radio stations in the event of a regional emergency.

All associates shall report to the primary or alternative work location as directed by supervisors or other WellCare management via the WellCare Emergency Hotline or other individual contact (e.g., phone, email).

In addition to the inbound communication outlined above, WellCare shall use phone trees and the Emergency Notification System to communicate with associates. As a result, it is critical that all associates maintain up-to-date contact information in the Human Resources portal including personal addresses, home phone numbers, personal cell phone numbers, and alternative email addresses.

All managers are responsible for downloading a current organizational contact report from the Human Resources portal on a regular basis and immediately preceding an anticipated emergency.

1.12 Associate Communications

All associates are updated before, during and after an event via the Emergency Hotline, WellCare Link, the Emergency Notification System and departmental call trees. When possible, associates are notified of emergency events in advance. Associate communications include actions the associate should take before, during and after an event, as well as how to receive on-going updates.

1.13 Member & Provider Communications & Continuity

WellCare members and providers are updated before, during and after an event via the WellCare website(s) and normal channels of communications. The business areas responsible for normal day to day member & provider communications are also responsible for communications in an emergency event. These procedures are outlined in their EPP documentation.

Processes necessary to maintain services with WellCare members and providers are outlined in the appropriate business area EPPs. These plans describe how member and provider services will be maintained during an emergency event.

APPENDIX A: EPC CHARTER

1.1 Purpose

WellCare Health Plans, Inc. and its subsidiaries (collectively "WellCare" or the "Company") are committed to developing and implementing comprehensive, compliant business continuity and disaster recovery plans (collectively "emergency preparedness plans" or "EPPs") that protect associates and ensure the survival of the Company. To that end, WellCare has established an Emergency Preparedness Committee (the "EPC") to collaborate on and coordinate enterprise-wide emergency preparedness issues and matters. The primary duties and responsibilities of the EPC are set forth below.

The EPC shall provide planning and guidance to allow the Company to respond to business disruptions by:

- Safeguarding associates' lives and Company property
- Making operational and financial assessments and decisions
- Quickly recovering and resuming operations
- Protecting all of the organization's records and data
- Maintaining regulatory compliance
- Allowing members access to uninterrupted services

1.2 Duties and Responsibilities

The responsibility of the EPC is to ensure each critical functional area within the Company develops a contingency plan that achieves the following:

- Identifies necessary resources to enact the contingency plan
- Provides for the safety and well-being of the people on the impacted premise at the time of the disaster
- Continues critical business operations
- Outlines contingency and backup processes and procedures
- Minimizes immediate damage and loss
- Facilitates effective coordination of recovery tasks
- Calls for regular updating of the functional plans
- Aligns with the other functional area contingency plans
- Aligns with the Company information systems disaster recovery capabilities

The EPC shall be responsible for monitoring situations and incidents that could lead to the declaration of an emergency and keeping Company associates and senior management briefed on such situations as necessary. Additionally, the EPC shall be responsible for providing recommendations to the Company's executive management team via the EP Steering Committee regarding the declaration of an emergency and any associated decision-making.

1.3 EPC Oversight

EPC Members shall be appointed by the business area leaders and shall include representation from every area of the Company. The EP Lead shall be appointed by the EP Executive Sponsor. The EP Steering Committee and the EP Executive Sponsor shall be appointed by the CEO. The EP Steering Committee may include, but is not limited to, the Senior Management Team. Oversight of the EPC shall be by the EP Steering Committee via the EP Lead and the EP Executive Sponsor. It shall be the responsibility of the EP Steering Committee, in consultation with the CEO, to make emergency declarations and other critical decisions.

Escalation from the EPC shall be via the EP Lead to the Emergency Preparedness Executive Sponsor. The EP Executive Sponsor provides guidance to the EP Lead and the EPC as well as acts as the chief liaison to the EP Steering Committee. The EP Steering Committee is comprised of WellCare executive leadership and the EP Executive Sponsor serves as its Lead.

1.4 EPC Membership and Meetings

The Emergency Preparedness Lead shall preside over all meetings of the EPC at which he or she is present and shall act as the chief liaison between the EPC and the EP Executive Sponsor and the EP Steering Committee. The EP Lead shall be responsible for maintaining the Corporate EPP, facilitating the activities of the EPC and its representatives, and otherwise serving as a central point of contact for WellCare's emergency preparedness activities. The EP Lead shall appoint a backup to preside over meetings the Lead is unable to attend and otherwise act in the stead of the Lead as needed. The EP Lead may appoint an EPC secretary who shall give notice of all EPC meetings, prepare agendas, record, maintain and distribute minutes, and maintain the WellCare Emergency Preparedness SharePoint site.

The EPC shall convene at least quarterly to review the status of WellCare's emergency planning activities, report updates by area, and/or assign tasks necessary to improve WellCare's Corporate EPP. Additional EPC meetings shall be convened as necessary to review possible emergency situations and make the determination when/if to escalate situations for formal emergency declaration.

1.5 Amendments

This Charter may be amended only after a two-thirds vote of the EPC membership followed by approval by the EP Lead and EP Executive Sponsor.

APPENDIX B: GLOSSARY OF COMMON TERMS AND ACRONYMS

Term	Definition
Activation (or Plan Activation)	When all or a portion of an EPP has been put into motion.
Alert	Notification that an incident with potential for disaster has occurred- stand by for possible activation of recovery plan.
Alternate Site	A location, other than the normal facility, used to process data and/or conduct critical business functions in case of an actual declared disaster.
Anticipated Event	An emergency event, such as a hurricane, that has some advanced warning, which provides an opportunity for "response" and planning prior to the actual event as well as after the event.
Area (or Business Area)	Multiple WellCare departments and/or divisions reporting to a WellCare vice president or area leader.
Assumptions	Basic, pre-determined conditions that will be in place if an incident occurs.
Business Continuity Plan (BCP)	Documentation of WellCare's strategic capabilities for ensuring the continuity of member, provider, and vendor services in response to man-made or natural disasters and other emergency situations.
Business Function	A working group performing a common activity. Each major business function should be represented in a Team.
Corporate Emergency Preparedness Plan (Corporate EPP)	The strategic Corporate Business Continuity Plan (BCP) and Disaster Recovery Plan (DRP) for WellCare Health Plans, Inc., herein referred to as WellCare, includes elements common across business functions. This document does not account for the entirety of WellCare's EPP. Instead, this document is a 'parent' document to several area EPPs.
Damage Assessment	The process of assessing damage following an incident to computer hardware, vital records, office facilities, etc., and determining what can be salvaged or restored and what must be replaced.
Disaster Declaration (or Emergency Declaration)	An official decision by the EP Steering Team to activate the WellCare Corporate EPP.
Disaster (also see Emergency Event)	Any event that prevents or creates an inability by an organization or business function from performing critical work within an acceptable timeframe for some future period of time. An event is classified as a "disaster" only after an official declaration has been made.
Disaster Recovery Plan (DRP)	Documentation of WellCare's immediate response and subsequent recovery from an unplanned business interruption within WellCare, such as loss of utility service, building evacuation, or a catastrophic event such as a major

Term	Definition
	fire or hurricane.
Emergency Management Team (EMT)	Area group that provides overall coordination of response and recovery support activities. Once an incident occurs, the EMT determines which response and recovery actions should be invoked based on the severity of the incident. EMT will provide centralized support and/or leadership to affected business functions.
Emergency Event	Whenever an event interrupts normal operations and it is reasonably anticipated that the interruption will last a significant amount of time. (also see "Disaster")
Emergency Preparedness Committee (EPC)	The governing body responsible for maintaining WellCare's Corporate EPP. The mission of WellCare's EPC is to provide the guidance and support that facilitates the development and implementation of all area EPPs
Emergency Preparedness Plan (EPP)	The combination of a business area's BCP and DRP.
EPC Representative	An associate that serves as point person for a WellCare business area and is responsible for communicating EPC actions and decisions to their respective area leadership and/or EMT.
EP Steering Committee	A group of WellCare leadership responsible for making emergency declarations and other critical decisions escalated by the EPC.
Information Technology (IT)	Business area that provides overall management and coordination of response and recovery support activities pertaining to essential information systems.
Interruption	Any event, whether anticipated (i.e., public service strike) or unanticipated (i.e., blackout), that disrupts the normal course of business operations.
Protected Health Information (PHI)	Confidential member health information that WellCare must protect during emergency situations as stringently as it does during normal operating conditions.
Recovery (or Business Recovery)	The ability to respond to an interruption in services by implementing a Disaster Recovery Plan to restore an organization's critical business functions. Also, the phase of the EPP plan that occurs after the emergency response is performed.
Recovery Procedures	Actions necessary to respond to an incident and eventually restore critical operations.
Response (or Emergency	Activities that go into effect immediately following an emergency event (if unanticipated), or immediately following indication of an anticipated event.

Term	Definition
Response)	This phase usually concludes after damage assessment concludes.
Restoration (or Emergency Restoration)	The planning process and activities for the restoration of normal operations at the primary (normal) business site.
Unanticipated Event	An emergency event that occurs without any advanced warning, such as a fire or utilities failure, so all business "response" and planning occurs after the actual event.
WellCare Corporate EPP	The aggregation of the Corporate EPP, the IT Infrastructure Disaster Recovery Plan and all WellCare business area BCPs.
WellCare Health Plans (WellCare)	General reference to the collection of government-paid health plans under the control of Comprehensive Health Management Inc.

APPENDIX C: EPC MEETING LOCATIONS AND CONFERENCE BRIDGE

In the event of an unanticipated emergency during which the EP Lead is unable to communicate meeting times and locations, the EP Steering Team shall immediately convene at the Tampa headquarters at the locations listed below. If the Tampa headquarters is not accessible, the EP Steering Committee shall convene at the first accessible alternative location listed below.

This conference bridge will be opened for those that are not able to attend in person:

Conference Bridge: (877) 848-7030
Participant Code: 9571545
Host Code : 2831

Emergency Planning Location 1	Renaissance 1
	Executive Board Room, 3rd Floor
	8725 Henderson Road
	Tampa, FL 33634
Emergency Planning Location 2	Pharmacy Building
	Independence Park 1 George Rd.
	4110 George Road, Suite 300; 150/100
	Tampa, FL 33634
Emergency Planning Location 3	Harborview Plaza
	Florida Sales
	3031 N. Rocky Point Dr., West Suite 600
	Tampa, FL 33607

SECTION IV.S CLAIMS MANAGEMENT

107. Describe the MCO's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the MCO's strategy for identifying problem areas, and how the MCO will ensure rapid response. *(Page limit 2 pages)*

ENSURING A FULLY DEVELOPED CLAIMS PROCESSING SYSTEM FOR NEBRASKA ON DAY1

WellCare's claims payment process for all medical and behavioral health claims is integrated within the same IT platform. Our claims process workflow is built with multiple reconciliation points throughout the lifecycle of the claims process. WellCare has performance metrics that include accuracy and timeliness of claim payments. The performance metrics also include a process for tracking the development and implementation of process improvements to claim payments. Through daily performance monitoring supported by accurate reporting tools, and effective technology; WellCare has demonstrated consistent improvement in claims processing turnaround times year-over-year. We keep records of these activities and can provide documentation to federal regulators and MLTC upon request.

BUILDING OUR CLAIMS STRATEGY FOR HERITAGE HEALTH

WellCare has a well-defined strategy which we will deploy for the claim payment process and ensure it is ready at the time of Nebraska's contract implementation. Our readiness plan initiates with the release of the RFP. We analyze the RFP on three broad categories:

- What processes are new to our existing claims readiness
- What modifications are required to the existing process
- What requirements are new for which solutions need to be developed

Based on this analysis, we develop a comprehensive project plan that includes our configuration, benefits, claims, EDI operations, IT, front-end, coding and fee schedule teams. Our Enterprise Project Management Office (ePMO) market initiatives team gets involved for developing a comprehensive project plan. The Claims team organizes weekly status meeting to measure the progress against the project plan.

For Nebraska, we will develop a customized process that will support Nebraska-specific regulations and will involve rigorous process initiation involving end-to-end testing, modular-unit testing and provider contract adjudication testing.

Identifying Problem Areas

A critical component of continuous claims process improvement is our auditing function. We perform claims audits in accordance with all applicable rules and regulations. The audit program is designed to minimize risk by increasing the accuracy of claims processing through performance feedback and root cause analysis. This program identifies deficiencies and works to resolve them for improved claims processing and payment. A dedicated claims audit team is responsible for reporting the financial accuracy of claim payments. This internal control activity supports early detection and corrective action of potential financial risk. Our independent registered accounting firm, Deloitte & Touche LLP, internal audit team and the senior management of WellCare monitor the findings. The objectives of the claims audit team are to provide reports that assist in effectively trending payment accuracy, identify payment and financial accuracy measures for root cause analysis, and to request and monitor corrective actions.

Rapid Resolution

WellCare will audit 100 percent of Nebraska provider claims for accuracy prior to releasing the claims during the initial go-live period. This will be accomplished by systematically reviewing claims during the adjudication process for quality audit review prior to releasing for payment. This will ensure accurate and

timely payments, identification of issues and enables root cause and/or resolution to occur prior to the claims release for payment or denial, if appropriate. Daily claims review sessions with a cross-functional team comprised of the following departments will occur for all areas to approve/sign-off on the pricing and benefit applications.

- Claims
- Configuration
- Benefits
- Fee Schedule
- Quality Audit
- Local health plan
- IT
- EDI-Operations
- Front End

The intense review by this cross-functional team accelerates the issue identification and resolution process. Rapid resolution occurs since all potential risks are identified, documented and tracked via an issues log, and actions are taken through resolution. If an issue is identified through this review we will work to fix the problem prior to payment to avoid an incorrect payment or denial. The review will allow proactive outreach to providers with high denial rates for education by the provider engagement team with a designated onsite resource if required. If a problem will result in a delay of payment for providers, we will directly outreach to the impacted provider(s) to discuss payment options available and come to a mutual agreement on timeframe and method of payment. This process will be gradually be removed by provider types. We then transition to our normal state of day-to-day monitoring when the desired outcomes are confirmed and realized for the claims to begin auto-adjudicating to the highest extent possible.

Our day-to-day management activities focus on monitoring daily performance and inventory. Our claims operations team alongside the areas above will review a variety of reports daily that will help us understand the current inventory of claims, at what stage of processing they are in, and whether we need to take action to course correct, such that we are on track to continue to meet and exceed service level agreements with providers and with MLTC.

This team also hosts a cross-functional meeting with members from other teams that impact the claims processing function to provide insight into what those teams are experiencing. This cross-functional meeting is held three times a week, and includes staff from our Information Technology (IT) team, which is responsible for systems operations and maintenance; our front-end team, who manages claims intake; our strategic operations team; and our EDI-operations team which manages provider connectivity. This cross-functional team assesses the entire claims work flow.

SECTION IV.S CLAIMS MANAGEMENT

108. Describe the MCO's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address:

- The process for auditing claims samples.
- Documentation of the results of these audits.
- The processes for implementing any necessary corrective actions resulting from the audit.

(Page limit 3 pages)

WELLCARE'S METHODOLOGY FOR ENSURING ACCURATE, TIMELY CLAIMS PAYMENT

WellCare uses a number of proven approaches and methodologies to monitor claims processing throughout the entire claims life cycle. Our claims process workflow is highly controlled with monitoring, reconciliation and intervention points embedded along the way. On a daily basis, our Claims Command team vigilantly monitors claims inventory in the various phases of the workflow through performance metrics including, but not limited to month-to-date turnaround time, auto-adjudication rates, and production outputs. Any deviations or activities that may affect claims output for our providers and members is transparently shared with our service personnel, regional counterparts and providers.

By the Numbers: Processes in Action

In 2015 (through November), WellCare processed 96.75% of all clean claims within 14 calendar days of receipt.

We actively encourage the use of electronic transactions whenever possible, supporting all industry standard transactions and formats. The key components of our Claims and Encounter Processing solution, which apply to all service types including participating and non-participating providers (inpatient, outpatient, pharmacy, vision, etc.) include: intake and validation, adjudication and clinical edits, provider payment, encounter submission, daily report of pre-adjudicated shadow claims, and provider filing limit. Claims operations metrics are reported and reviewed by management on a daily basis to include payment accuracy, prompt pay results and auto-adjudication percentage.

WellCare will measure and utilize existing performance guarantees in accordance with the Nebraska RFP; 90 percent of all clean claims within 15 business days of receipt, 99 percent of all clean claims within 60 calendar days of the date of receipt. Our staffing model takes into consideration these metrics so that all state requirements are satisfied.

PROCESS OF AUDITING CLAIMS

A critical component of continuous claims process improvement is our **auditing function**. We perform claims audits in accordance with all applicable rules and regulations. The audit program is designed to minimize risk by increasing the accuracy of claims processing through performance feedback and root cause analysis. This program identifies deficiencies and works to resolve them for improved claims processing and payment. A dedicated Claims Audit team is responsible for reporting the financial accuracy of medical claim payments. This internal control activity supports early detection and corrective action of potential financial risk. Our independent registered accounting firm (Deloitte & Touche, LLP), Internal audit team and senior management of WellCare monitor the findings. The objectives of the Claims Audit team are to provide reports that assist in effectively trending payment accuracy, to identify payment and financial accuracy measures for root cause analysis, and to request and monitor corrective actions.

The following types of audits are performed by the WellCare Claims Audit team:

- **Sarbanes-Oxley Compliance Audit (SCA):** The SCA process is designed to ensure the system logic complies with state and federal guidelines, designated contracts, changes approved by management (in the form of business decisions) and department processes and procedures and the SCA process also ensures that decision documents are approved within our compliance guidelines and that all items are implemented appropriately.
- **User Compliance Audit (UCA):** UCA's are conducted to identify opportunities to improve financial accuracy through the clarification of training and desk procedures and staff training as well as associate performance management.
- **Targeted Compliance Audit (TCA):** TCA's are performed on new operating activities or areas of concern.
- **High Dollar:** This audit is a pre-payment review on claims with a net paid amount of over $50,000 and is performed to minimize the financial risk on high dollar claims by validating the payment amount before the claim adjudicates.
- **Delegated Entity (DE):** The DE audit works directly with the Delegation and Oversight team to ensure payment accuracy for our delegated vendors. We monitor compliance with applicable standards in accordance with federal and state requirements. WellCare has established the Delegation Oversight Committee (DOC) to be responsible for functions that we delegate to third parties. The DOC must ensure appropriate performance measures are in place to ensure we can accurately assess whether delegated entities are in compliance with federal and state requirements.

Documenting Results

At WellCare, we have multiple methods for monitoring performance and ensuring transparency. These include Operation dashboards, Reports sent to Senior Management and the comprehensive scorecards generated for individual markets.

Accuracy goal for compliance audits

WellCare achieved 99% financial dollar accuracy and 97 % claim payment accuracy in claims payment audits.

In an effort to assist the operational units with the management of identified claims risk, the Claims Audit department uses an application to record mitigation plans. Payment errors are logged and tracked in the centralized audit tool called the **Audit Workbench** to ensure corrective actions and mitigation plans have been provided. A report of all affected claims is also created and tracked to verify that appropriate action was taken on all impacted claims.

This application is used by all areas of operations in tracking the root cause and mitigation plan for claim payment errors identified through our audit processes. The application includes a module for generating control reports to identify the final disposition and corrective action of the error.

The process used to record the error disposition and action plan within the application is as follows:

- The Claims Audit team enters payment errors daily.
- The operational unit responsible enters the root cause and mitigation plan for each error.
- The overall dollar amount and claims volume resulting from the error are entered to determine the impact and track the correction of the erroneous payments. Each mitigation plan explains the process of updating or adjusting the correct claim payments in WellCare's system, and if necessary, the Payment Recovery Team will issue a work order ticket to collect any erroneous payments.
- Errors will remain open until the mitigation plan has been completed and all necessary claim

adjustments have been made.

Claims Audit associates validate that risk mitigation plans are complete which are important elements in completing corrective actions. All of this activity is captured in the Audit Workbench tool. Depending on the severity of the risks, a mitigation process is planned. Once the risks are identified, weekly meetings are held by the Claims Audit and Operations teams to review the status of necessary actions. The pending risks are presented to area management or senior management for mitigation. Finally our IT department completes a monthly report that tracks mitigation plan action log activities and open items.

Overall the audit results can lead to adjustment of claims, root cause determination and corrective action plans. The action plan and the claims to be adjusted are monitored through the Open Action Log and adjustment reports.

Corrective actions

Our Claims Audit department is a key control to mitigating claims financial risk in coordination with Internal Audit. Quarterly, a risk area summary report is reviewed by the Risk Champion (the area leader is champions the mitigation plan) to ensure that WellCare's Enterprise Risk Management (ERM) plan is up to date. The ERM report shows that in our risk assessment management plan each risk event has a representative risk mitigation activity, key performance indicators and acceptable range or target to measure success.

The Claims Audit department, in its monthly executive performance report, will rely on corrective action management reports to document and direct corrective actions. The errors are identified in the dashboard which is shared with Operations and Executive teams monthly as it relates to identified claims accuracy errors controlled through an Audit Tool. The log of claim errors that have mitigation plans on file and those that have yet to be completed is also shared with the Executive team.

SECTION IV.S CLAIMS MANAGEMENT

109. Describe in detail how the MCO will verify that services were actually provided including:

- Minimum sampling criteria to ensure a representative sample.
- How results of monitoring will be reported to the State quarterly.

(Page limit 3 pages)

WELLCARE'S PROCESS OF SAMPLING AND MONITORING VERIFICATION OF SERVICES

As part of our robust efforts to root out Fraud, Waste and Abuse, WellCare has developed a broad range of tools including a verification of services (VOS) process we use to validate that services billed and paid for were actually provided. Through this verification process we will send a notice to a random sampling of members each month that would contain billed claim information specific to the member.

We will implement the VOS process upon approval by the State of Nebraska. This process encompasses sending a notice that will include a cover letter that explains the document, required actions for the member, and a summary of the services to be verified. The notice also informs the member that he/she should contact our Special Investigations Unit (SIU) hotline if he or she has any questions.

The hotline is manned by the SIU personnel. The SIU will investigate member reports, and when a member report indicates potential fraud or abuse, WellCare will report the information to the State and the Office of Attorney General (OIG) on its standard form for reporting suspected fraud and abuse in compliance with the Contract.

SAMPLING CRITERIA

Sampling will be done on three categories of payments for both professional claims as well as three categories of institutional claims. This will include all provider types (or specialties) including behavioral health, pharmacy, and unique claims from FQHC's, RHC's and tribal clinics.

The sample size will be no less than two percent of claims per month and divided according to the breakdown listed below as referred in the table below.

Professional Claims: There are three categories of professional claims as shown in **Figure 1** below. The categories are determined by the distribution of the claims data for the prior five months.

Figure 1

CATEGORY	DESCRIPTION	SAMPLE SIZE
1	Paid amount >= $500	The larger of the statistical sample size with 95% confidence level and 10% of precision or 20% of the member count.
2	Paid amount >= $100 and < $500	The larger of the statistical sample size with 95% confidence level and 10% of precision or 10% of the member count.
3	Paid amount >= $50 and < $100	The statistical sample size with 95% confidence level and 10% of precision.
Paid Amount is the total amount within a one-month period for each member.		

Institutional Claims: The three categories (as shown in **Figure 2**) of institutional claims are determined by the distribution of the claims data for the prior five months.

Figure 2

CATEGORY	DESCRIPTION	SAMPLE SIZE
1	Paid amount >= $5,000	The larger of the statistical sample size with 95% confidence level and 10% of precision or 20% of the member count.
2	Paid amount >= $1,000 and < $5,000	The larger of the statistical sample size with 95% confidence level and 10% of precision or 10% of the member count.
3	Paid amount >= $100 and < $1,000	The statistical sample size with 95% confidence level and 10% of precision.
Paid Amount is the total amount within a one-month period for each member.		

Monitoring

The SIU is our dedicated team responsible for monitoring, detection, prevention, investigation, reporting, correction, and deterrence of fraudulent claims. The SIU is a vital component of our Compliance department and maintains written policies, procedures, and standards of conduct that drive WellCare's actions to monitor and detect fraud. We have established SIU as part of a comprehensive anti-fraud program designed to prevent, detect, investigate, resolve, correct and report incidents of suspected fraud, waste and abuse (FWA). We will take necessary actions to comply with the erroneous payment requirements as outlined in this RFP.

The SIU commences an inquiry within 14 days of a suspected matter of FWA being reported to the SIU. Once received, the matter is entered into the secure case management data base. The entry is preliminarily triaged by the intake team to confirm that the matter concerns potential FWA. If the SIU determines that further investigation is warranted, the SIU completes due diligence and, where appropriate, refers the matter to the appropriate authorities as potential FWA. The SIU methodology is multi-faceted and uses a collaborative approach to identify and pursue potential cases of FWA.

These methods include:

- Operating an education and awareness training program to maximize employee, business partner, and downstream entity referrals to develop tips regarding possible FWA
- Investigating referrals from any source, including employees, business partners, law enforcement agencies and providers
- Utilizing a combination of data mining analytic tools, clinical expertise, and investigative knowledge to identify potential FWA
- Establishing baseline data to enhance efforts to recognize unusual trends or changes in utilization patterns

The SIU also uses business intelligence software to produce a Physician Trend Report by specialty. This report enables the SIU to identify aberrant spikes or trends. When this analysis identifies a provider with suspicious activity, a more detailed set of reports is generated, which allows investigators to view the entire billing and claims history for that provider. Additionally, as part of their due diligence SIU investigators use the Special Investigation Resource and Intelligence System (the National Health Care Anti-Fraud Association information-sharing website that includes regular postings of information about potential provider FWA activities by more than 100 insurance companies nationwide).

Reporting

For Nebraska, our SIU will send quarterly reports to MLTC which encompasses the following:

- Number of claims extracted per month
- Number of responses received from members through the hotline
- SIU's course of action
- Final determination

In addition to the individual reporting of suspected claims, we will routinely submit the following reports to MLTC:

- Fraud and Abuse and Pharmacy Lock-In reports to ensure all cases of suspected FWA are reported in a timely manner.
- Quarterly Behavioral Health Report
- Reports of all program integrity settlement agreements entered into with providers within seven business days of the settlement

SECTION IV.S CLAIMS MANAGEMENT

110. Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status. *(Page limit 2 pages)*

WELLCARE'S DRUG REFERENCE DATABASE

WellCare has extensive experience managing the pharmacy needs of our members. Currently, we are serving the pharmacy needs of 2.4 million Medicaid members across nine states. ***Annually, we manage more than 200,000 pharmacy prior authorizations across all of our Medicaid plans with nearly 100 percent resolved within 24 hours where required.*** WellCare's pharmacy program seeks to steward pharmacy resources without delaying care, improve member outcomes, improve access and support and engage our members and providers. Our goals are safety, efficacy and efficiency. Using the Nebraska Medicaid Preferred Drug List (PDL), WellCare will provide formulary coverage, at a minimum, for all classes of drugs including over-the counter (OTC), to the same extent they are covered by the Nebraska Medicaid Fee-For-Service (FFS) pharmacy benefit. Our Director of Pharmacy for Nebraska will work collaboratively with our corporate pharmacy department to coordinate the necessary clinical services and to ensure appropriate pharmacy benefit design, decision-making criteria, and formulary exceptions are followed based on Nebraska PDL and Utilization Management (UM) criteria.

WellCare's pharmacy operation is a unique hybrid model with a number of critical pharmacy benefit management functions performed in-house by WellCare personnel, coupled with the activities of a pharmacy benefits manager (PBM). Beginning in 2015, we utilized CVS/Caremark as our Pharmacy Benefits Manager (PBM).Under our hybrid model, our corporate pharmacy resources are responsible for prior authorization determinations, appeals, formulary and management, claims testing, Pharmacy and Therapeutics (P&T) Committee activities, quality improvement, retrospective drug utilization reviews, rebate management, and members and provider communications.

For Nebraska our PBM, CVS/Caremark, will manage the pharmacy benefits for our Heritage Health members. CVS/Caremark has a well-defined database, MediSpan, which it uses for pharmacy claims processing, updating schedules, term dates, obsolete dates and rebate status. MediSpan sends and loads a daily drug file into CVS/Caremark's test and production environment. The CVS /Caremark operations team then reviews the daily drug file in the staging and production environment by confirming that the files were loaded and that the necessary reports are available. Finally, CVS/Caremark operations logs the records as accepted or rejected and corrects any rejected records. Beginning October 1st, 2015, WellCare also maintains its own MediSpan database for processing all operational functions, prior authorizations and ensures proper coordination with the PBM.

Updating Schedules, Obsolete Dates and Rebate Dates

Any updates to the drug file are performed daily through the MediSpan database and the CVS/Caremark plan configuration is designed to prevent payment of claims submitted by pharmacies after the manufacturer term date, obsolete date or rebate eligible product date.

CVS/Caremark processes daily drug files from MediSpan to update Average Wholesale Price (AWP) unit and package pricing (data) on a daily basis, (Tuesday through Saturday). To deliver and load the daily drug file into the (staging) environment, MediSpan does the following:

- Provides to CVS/Caremark a daily drug file containing AWP unit and package price. This file is used to maintain and update the CVS/Caremark's price data.
- The daily file is available from MediSpan Monday through Friday. CVS/Caremark's FTP tool, transfers the file from the MediSpan server to CVS/Caremark server Monday through Friday evening. The automatic load of the files happens Tuesday - Saturday beginning 2 AM.

- When the file load is complete, it sends multiple automated e-mails to CVS/Caremark's Clinical Operations and Support Benefits teams indicating that:
  - The Daily Drug File on *<yyyy/mm/dd>* is loaded on day, month, date and time with no rejected records in all four price types.
  - Load reports and specialty pricing reports are available for review once the load is completed
- CVS/Caremark Operations reviews the file.
- If a daily file is not sent for any reason, CVS/Caremark follows up with MediSpan to resolve the problem. Once the file is received, it is manually loaded to ensure all the processing environments (i.e., staging and production) are up to date.
- Logs records as loaded or rejected with the corresponding date in the row assigned to STAGING in the daily load report file located on the department shared drive.

MediSpan Benefits the State, Providers and our Members

MediSpan is becoming a standard for claims processing due to its increasing usage among the major PBM's and MCO's. Using the same database in our internal operations as well as by our PBM ensures a seamless operation to our members, providers and pharmacies. The claims process is updated on a daily basis and allows the State to have accurate data and avoid any underpayment or overpayment.

SECTION IV.S CLAIMS MANAGEMENT

111. Describe how the State Medicaid PDL will be integrated into the MCO pharmacy claims system. *(Page limit 2 pages)*

INTEGRATION OF NEBRASKA MEDICAID PDL INTO WELLCARE CLAIMS SYSTEM

WellCare's pharmacy department has a long history of managing state Preferred Drug Lists (PDL)'s. As recently as 2014, we implemented the State of Florida's Medicaid Preferred Drug List for our Florida Medicaid business. The PDL clearly communicates the parameters of coverage, details about our coverage, and outlines our prior authorization requirements.

We will use the Nebraska PDL as developed by MLTC with input from our Medicaid Pharmacy and Therapeutics (P&T) Committee to inform prescribers of the most cost-effective drug therapies. This will include utilization management, enforcement of prior authorization criteria, quantity limits, and days' supply limitations designated by the Nebraska PDL. WellCare and CVS/Caremark will complete a validation and approval process for integrating the PDL into WellCare's PDL.

WellCare will provide our PBM, CVS/Caremark, with the approved Preferred Drug List (PDL), full National Drug Code (NDC) list and Utilization Management (prior authorization criteria, quantity limits, age limits and step therapy edit) files from the State of Nebraska. These files will be used for implementation and changes to the State's specific plan designs and clinical programs.

WellCare will work with CVS/Caremark to create a PDL coding grid which will outline the messaging for each claim scenario, categories excluded from the benefit, and all other state specific requirements. We will work with the PBM to ensure that the approved changes to the PDL are submitted to the CVS/Caremark benefits for system coding within the States required turnaround time. All updates will be tested for accuracy prior to implementation in order to achieve accurate adjudication of the medication claim at the point of service.

The Nebraska PDL will be sent via the WellCare formulary team for uploading into the PBM system. However those medications that are not included on the Nebraska state PDL, but must be covered under the Affordable Care Act, WellCare will send the list to our PBM via the use of Form F. Form F will also be used for any changes made due to P&T meetings, FDA changes and Micromedix changes. Refer to **Figure 3** below.

Figure 3

CHANGES TO THE PDL WITH THE GENERATION OF FORM F
The Clinical Pharmacy Formulary Manager reviews the Form F
➢ The Clinical Pharmacy Formulary Manager changes the Form F status in SharePoint to (FC Name)-Reconsideration ➢ Notifies the Formulary Coordinator via email to make the necessary change(s) ➢ Makes the requested change(s), changes the Form F status in SharePoint back to (FC Name)-Complete and notifies the Clinical Pharmacy Formulary Manager via email ➢ Reviews the Form F for accuracy
The Clinical Pharmacy Formulary Manager reviews Form F
➢ Approves Form F by initialing each line in the spreadsheet and electronically signing the document ➢ Changes the Form F status to (Manager Name)-Complete ➢ Notifies the Director via email that Form F is ready for final review and signature
The Clinical Pharmacy Director reviews Form F
➢ Review Form F and sign-off by placing initials on each line

- Approves Form F by electronically signing and protecting the document
- Changes Form F status to (Director Name)-Complete and notifies the Formulary Coordinator via email that Form F has been approved

The WCG Formulary Coordinator

- Ensures that the all rows and columns in the Form F spreadsheet are viewable and none are hidden
- Verifies that each line has the Manager's and Director's initials, and both have electronically signed the document
- Forward the Director's email of approval with the Form F attached to PBM for programming

The PBM Account Manager

- Completes an Add/Change (A/C) form for each line of business for programming purposes
- Assigns a Track/Case number along with an effective date for each Add/Change form
- Includes the Track/Case numbers and effective dates on the PBM Weekly Activity Log which is emailed to WCG Formulary Services at the beginning of each week

The WCG Formulary Coordinator

- Compares the documentation on the Weekly Activity Log with the programming requests on Form F to ensure consistency
- Documents the Track/Case numbers and effective dates on Form F in SharePoint and takes note of the effective dates for QA testing
- Confirms the accuracy of the programming changes by running test claims for each line on Form F
- Resubmits any programming errors on the Error Log to PBM via email weekly

WellCare will conduct comprehensive PDL testing prior to go-live on January 1, 2017 to ensure an accurate integration into the PBM claims system. The testing will include PDL and non-PDL medications for members in and out of transition and testing of all utilization management edits. In addition, paid and rejected claims will be monitored post go-live to ensure an accurate integration into the PBM claims system.

SECTION IV.S CLAIMS MANAGEMENT

112. Describe the MCO's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the MCO proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor. *(Page limit 5 pages)*

WELLCARE'S APPROACH TO ENCOUNTER DATA SUBMISSIONS

WellCare has a comprehensive and robust end to end encounter management solution. Our Encounters department complies with the encounter submission requirements such as formatting as outlined in *Section S. Claims Management* of the SOW. We process, on average, 3.6 million encounters monthly using a single encounters processing system. Our Encounters department is located in Tampa, Florida and will serve MLTC, our Nebraska provider network and Heritage Health members. We ensure that the medical and pharmacy data submitted is in the appropriate format and is a true reflection of all services and payments made. Following regulatory guidelines and procedures, our experienced associates drive and execute change to ensure timely, accurate, and complete encounter data.

By the Numbers: A Case Study

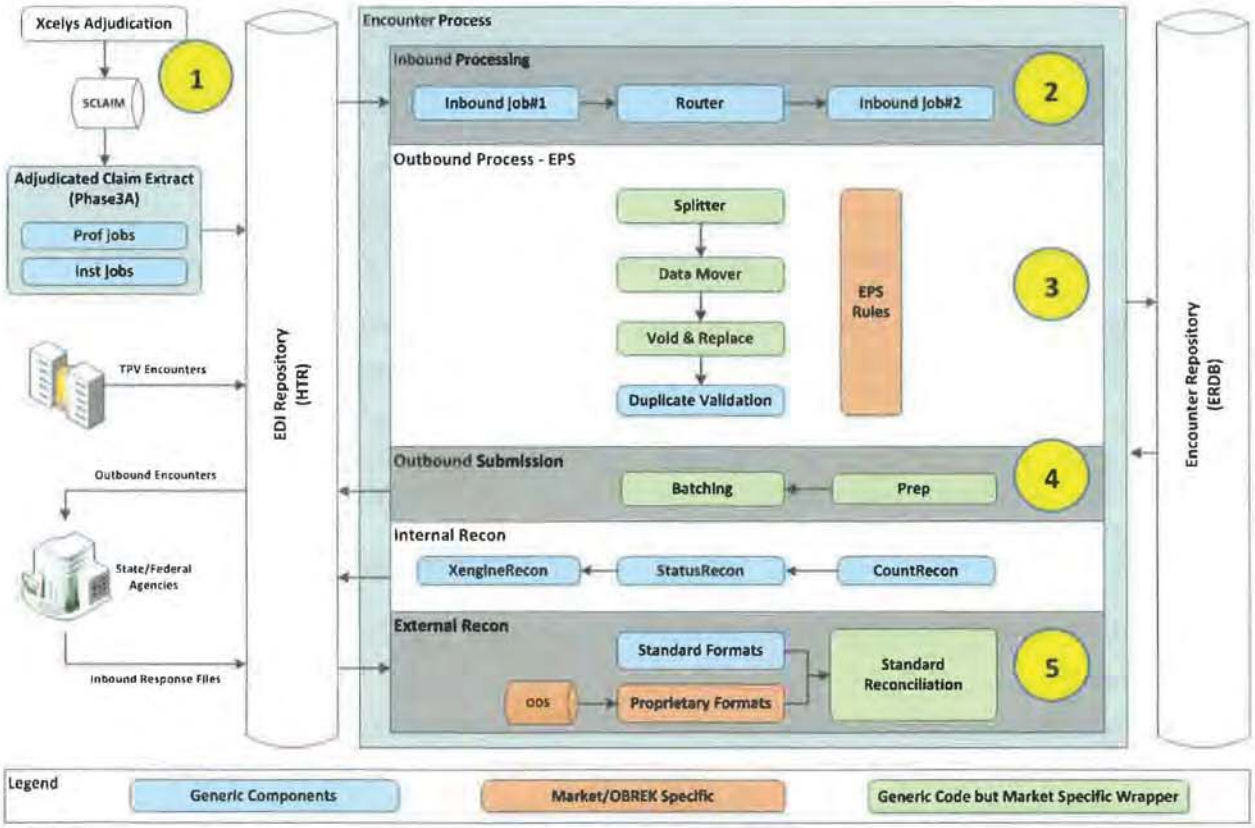
In Georgia, on average, we process 525,000 encounters per month with an acceptance rate of 99.36%.

Process overview

The WellCare encounters team creates encounters in 13 different formats for our 22 lines of business. Our encounters process (refer to **Figure 4**) can be broken out into five key areas:

- Adjudicated claims are extracted and data validation is performed.
- Inbound processing uses the extracted data from our claims adjudication system and extracts data from our subcontractor's encounter data.
- Outbound processing applies specific logic and edits, including claims splitting and service line roll up and will use them based on Nebraska specific requirements.
- Encounter data is batched and submitted. We also apply outbound Strategic National Implementation Process (SNIP) edits to validate transaction integrity prior to submission.
- Reconciliation is the final element which includes processing of response files. For Nebraska, we will design it to ensure previous versions of an encounter are at a final disposition prior to submitting a Void or Replacement transaction.

Figure 4



The Nebraska Encounter Operations Team: Experience and Expertise

WellCare is already equipped with an array of experienced encounter data team members who will be responsible for setting up the submission and reconciliation processes in Nebraska. These individuals are dedicated to the project through go-live. Upon contract award, WellCare will begin to search for Encounter Data Coordinators who will support the submission and reconciliation process in Nebraska. These individuals will be responsible for ensuring encounter data is complete, accurate and timely. They will also work closely to answer questions and perform testing during the pre-go live phase. Responsibilities will also include post go-live submissions and remediation of any issues that may arise.

WellCare's Encounter Inter-Disciplinary Team (EIDT)

Having a coordinated, collaborative group focusing on making sure encounter data is the accurate reflection of all services and payments is a strategic advantage at WellCare. The EIDT, internally called the Claims to Encounters End to End Steering Committee, is focused on implementing the strategy and resolving issues related to encounter data. The team consists of representatives along the entire claims to encounter value chain. We meet regularly to review and approve enhancements to our edit logic. For Nebraska, we will also work closely with the Heritage Health provider relations department to ensure all changes are communicated to our provider and subcontractor network.

Aligning Claims and Inbound Encounter Data Edits with Nebraska Edits

WellCare will apply a set of standard edits to our inbound claims and encounter data. In addition, WellCare will implement Nebraska specific data requirements and request a list of edits from MLTC.

Generally our work is completed to configure our editing tools to ensure proper alignment. We publish

837 claims companion guides and communicate necessary edits to our provider community. All editing and communication takes place prior to our go-live date. One of our key levers to ensure compliance with encounter data requirements is to have embedded specific contract language which will require subcontractors to submit data within 90 days. We then use provider scorecards to measure and report on this service level agreement.

Encounter Data Testing with Subcontractors

We use subcontractors for vision, and other ancillary benefits, and the subcontractors are required to submit encounter data in the 837 format. Each subcontractor undergoes onboarding, training, and data testing. We also configure reporting to show compliance with our quality and timeliness standards. For Nebraska, WellCare will receive this data from each subcontractor in compliance with MLTC data requirements and will complete all onboarding and testing prior to go-live.

Encounter Data Submissions

WellCare reviews the State specific companion guides, memoranda and other materials regarding submission requirements. During the UAT period we have some level of encounter data testing, and we work to create test data, submit test files and resolve issues. This process includes developing duplicate, void and replace, and other logic in order to be compliant with our submissions. In Nebraska we will meet all the required submission requirements in time for go-live.

Data Reconciliation Processes

To create our automated reconciliation process, we review all encounter data response file specifications. We work internally to load response files into our Data Warehouse and reconcile the responses with our encounter data submissions. We tag each encounter as "Accepted" or "Rejected" in order to build reporting and remediation plans.

Collaboration with MLTC management and technical staff

We are committed to working with our state partners as we work through a variety of policy and operational issues. This collaboration extends to encounter data collection and validation; we create a shared understanding of data quality standards and reporting on our Service Level Agreements. We also believe having a forum for resolving problems will create shared goals, and clear lines of communication. We welcome both formal and information communication paths in individual plan meetings and joint meetings with all plans. In our past experience, weekly meetings with our state partners are critically important initially to share policy, data submission requirements, file submission and reporting schedules and data rejections.

ENCOUNTER PROCESSING OVERSIGHT AND MONITORING TO ENSURE DATA COMPLETENESS

WellCare has also built comprehensive end to end reporting to provide immediate visibility to system, data and provider issues which affords the appropriate department to remediate quickly thereby guaranteeing a successful submission. There are multiple reports created to provide a holistic accounting of each and every encounter received, processed, submitted and reconciled from the Medicaid agency including:

- **Service Level (SLA) Reporting:** The SLA report tracks the timeliness, completeness and quality measures. They are created monthly and their intent is to provide visibility to those encounters that are nearing or outside of the SLA. The Encounter Data Coordinators work on these reports and remediate encounter data ensuring our agreements are met.
- **Cash Disbursement Journal (CDJ) Reconciliation:** The CDJ Reconciliation is a measure of completeness which compares paid encounters accepted by the Medicaid agency as a percentage of total dollars paid by WellCare for FFS and pharmacy providers on a rolling 12 month period. It is created monthly and reviewed by Encounters and Finance area leadership as a critical reporting tool.

Goals are established to achieve improvements year over year and variances require explanation.

- **Global Remediate Report (GRR):** The GRR is a measure of completeness to monitor encounters processing and to identify potential issues requiring further research and/or corrective action.
- **Standardized Work Plan Remediation:** WellCare has implemented a standardized remediation process which includes regular reporting feeding automatically into a standard work plan used as the primary driver for encounter remediation. The work plan provides a holistic view of all open items, issues and challenges for a particular state enabling the encounters team to remediate quickly thereby meeting state defined SLAs. These work plans are refreshed weekly and ensure current and accurate reporting is available to management and leadership teams. The standard work plan provides visibility to all open items across claim types based on total encounter inventory. Items are prioritized based on overall impact and risk to meeting specific service levels. It also provides tracking for all open items within cross-functional areas outside encounters including open questions with the state where there is a response dependency before moving forward on remediation steps. Finally, it provides a summary level of our current submission status and any gaps that may exist between it and the defined state SLAs.
- **Quarterly State Communications**: The quarterly state communication (also known as "quarterly letter") is developed to highlight current accomplishments, issues and to identify assistance MCOs may need with encounter data submission. These notifications are meant to summarize key items that are currently being worked on and provide the level of transparency needed in order to make our data submission successful.

WellCare's Success in the Monitoring Process

For Illinois, our Encounters Operations team, in conjunction with other cross-functional partners, recently worked with a local IPA in Kane County to bring them into compliance completeness and accuracy service level agreements. We utilized the Provider Scorecard to provide feedback about encounter data submission lacking quality and consistency. We tracked more than 9,600 encounters totaling $1.3 million. We reviewed specific errors with them and worked, over a period of three weeks, to have corrected encounter data submitted and the entire backlog resubmitted before the State's deadline. We resolved 97% of the IPA's encounters data error. WellCare continues utilizing the Scorecards monthly to ensure consistent submissions from this and every contractor that sends us data.

WellCare ensures complete and timely encounter data from our subcontractors using several methods described below:

- **Contract Language**: WellCare's contracts have specific language detailing the requirement for encounter data submissions. The subcontractor submits encounters in a HIPAA compliant 837 transaction format. Encounter transactions are required to meet standard rules set by the SNIP edits as well as comply with all state and federal validation guidelines. Any encounter that does not meet these requirements must be reviewed, adjusted and resubmitted by the subcontractor within thirty days of the initial notification of rejection. WellCare provides HIPAA standard response files as well as custom reports which are reviewed by the contractor. Our subcontractor submits 100 percent (as tracked by CDJ/ 835) within 90 days from date of service, of all encounters to us with an overall acceptance rate of no less than 95 percent or as superseded by specific state or CMS Service Level Agreement. This scoring will be monitored monthly and measured as an aggregate of 12 months using the Encounter Scorecard Monthly reports. Penalties for not complying with the contract will result in damages; these will be included in contracts. An example of this type of penalty is having the contractor refund WellCare an amount of one percent of our annual capitation payments made to Contractor if the 95 percent yearly acceptance rate is not met.

- **Provider Scorecard:** A key inspection tool for contract compliance is the provider scorecard. The scorecard tracks submission frequency and volume, compliance and accuracy of provider submissions by subcontractor. It reports the number of encounters submitted by the contractor by month, the number passing WellCare's front end quality edits, and the number accepted by the Medicaid agency. These counts are reported for each provider and contractor and are used by management, the ancillary department and the market to manage contractor activity and to target visits and education.
- **Contractor Education:** Upon creation and dissemination of the provider scorecards, we schedule targeted education sessions. This education goal is to ensure quality submissions and teach contractors how to correct errors with their encounter data. We handle education telephonically.
- **Contract Enforcement:** WellCare utilizes the contract to enforce encounter data timeliness, completeness and accuracy if necessary. For Nebraska, we will develop Corrective Action plans and track adherence to the plan until the Contractor comes into compliance. Financial penalties will be incurred if encounter data acceptance levels are not met.

Pharmacy Encounter Data from the PBM

WellCare will utilize our PBM to develop the encounter data submission and reconcile the response files. The PBM and WellCare have a shared responsibility to correct any errors and to ensure all Nebraska Service Level agreements are met. There is specific contract language which requires accurate and timely submissions. Currently, the PBM supports D.0, Post Adjudication 4.2, and Post Adjudication 4.4; however, we will develop any type of file submission type as required by Nebraska (standard NCPDP or Proprietary). Upon contract award, WellCare and the PBM will develop specific requirements for the Nebraska submission, create test files, and work to create an extensive set of test scenarios. This test cycle will be essential for having accurate data submissions once the submission is fully in production. WellCare will utilize a Reporting package developed by the PBM to ensure accurate, timely, and complete submissions. There will be dedicated subject matters experts within our team who will specialize in pharmacy data and will support the Nebraska pharmacy submissions on a go-forward basis.

SECTION IV.S CLAIMS MANAGEMENT

113. Describe the MCO's proposed processes for coordination of benefits for dually-eligible members. *(Page limit 2 pages)*

Our coordination of benefits (COB) policies and procedures ensure that we are the payer of last resort in situations where members have Medicare as their primary insurance. Our robust claims processing instructions demonstrate our ability to process claims in accordance with state and federal rules and meets the requirements as outlined in *Section S.17 Coordination of Benefits for Dually-Eligible Members* of the scope of work. We also have established policies and procedures for processing claims where third party liability (TPL) coverage exists to ensure that claim payment does not exceed the Medicaid or contracted allowed amount less the other carrier payment amount.

Our innovative methods assist auto-adjudication of COB claims and increase the accuracy and payment turnaround time with processing COB claims by removing manual intervention. WellCare understands the intricacies of processing dual eligible/cross-over claims and has processes in place to identify non-covered Medicare services/providers. This system allows us to accurately process claims as primary without requiring additional burden on the provider having to bill Medicare to receive a denial prior to submitting the claim to WellCare.

OUR PROCESS OF COORDINATION OF BENEFITS

The coordination of benefits (COB) process begins by adding other primary health insurance (such as Medicare) coverage information to the member's record in the Core Processing System (CPS). The other coverage details include the following: carrier name (if member is covered under a Medicare Advantage plan), HICN (or policy number), coverage type (Part A only, Part B only or Parts A&B), effective dates, and termination dates.

WellCare systematically uploads Medicare coverage details from the State's 834 files to the member's COB history tables in our claims system without additional validation. WellCare's COB team also runs a daily process to ensure that any member enrolled in a dual plan code has the proper Medicare COB segment in the Claims Process System (CPS). This daily process will capture any missing Medicare coverage information that may not have been sent to us in the State's 834 files. The COB team can obtain the missing Medicare coverage information directly from the Medicare CMS MARx web portal.

Coordination of Benefits Shared With Our PBM

WellCare has a well-defined process of coordinating benefits with our PBM, CVS Caremark. The pharmacy claims are adjudicated online, in real-time, and submitted electronically to our PBM. Our PBM recognizes the member's other prescription drug coverage in order to coordinate prescription benefits between the different entities. When a secondary claim is submitted by the dispensing pharmacy, the PBM identifies the amount paid by the primary third-party payor and recalculates the amount owed. Any remaining balance owed is paid by the secondary payor, or the payor of last resort. In this case, WellCare's Medicaid line of business would be the payor of last resort.

As a Medicaid contractor, WellCare takes the responsibility for identifying and pursuing TPL for its Medicaid membership. Best efforts are made by WellCare to identify and coordinate with all third parties whom members may have a claim for payment or reimbursement for services. These third parties may include Medicare, any other group health insurance, any coverage under governmental programs, and any coverage required to be provided for by state law.

WellCare performs cost avoidance and third party liability identification activities under well-defined policies and procedures that conform to all federal and state requirements. For Nebraska Medicaid we will apply our same process and criteria for coordination of benefits to the dually eligible members.

IV.T Reporting and Deliverables

SECTION IV.T REPORTING AND DELIVERABLES

114. Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAPI Committee.

WELLCARE'S DASHBOARDS TO TRACK PERFORMANCE

WellCare leadership uses an array of tools to help us monitor and track performance of a vast array of operational, clinical, financial and system performance metrics to ensure we are meeting and exceeding our obligations to our customers, as well as the expectations of our Board of Directors and executive leadership. We look at these metrics in dashboard and long report form and review data at the aggregate, local and line of business level to gain a clear understanding of individual strengths and challenges. In addition to internal use of our various dashboards and reports, we are well versed in customizing dashboards for individual state partners to meet the unique needs of each Medicaid agency with which we work. We have included in the body of this response or as an attachment a sampling of dashboards we use for tracking performance. We are highlighting here four examples of these reports, each demonstrating different capabilities and different audiences. The four samples used for this response include:

- Claims Payment Metrics
- Call Center Performance
- Quality Improvement Committee Reporting
- Local Health Plan Dashboard

Claims dashboards

WellCare maintains a Claims Command Center (CCC) to facilitate the management of claims inventory workload while ensuring greater predictability and optimal resource utilization from claim receipt-to-payment. The CCC monitors, tracks and measures claims data performance on a daily basis, which includes incoming receipts, inventory aging and numerous metrics reports. The team works to identify trends, variances and forecast work-on-hand throughout the claims processing flow utilizing our workflow management tools. A vital aspect of the CCC is to monitor end-to end claims tracking, reconciliation and acknowledgement of claims in transit.

WellCare utilizes data on a consistent basis through our monitoring tools as leading indicators to improve accuracy and provider satisfaction:

- Top Denials by provider including dollars and volume - Enables proactive communication to providers to reduce denials
- Top Reasons for suspended claims - Provides WellCare the mechanism to conduct analysis on improving auto adjudication rate, which has a positive impact on accuracy and timely payment
- Daily monitoring of inventory as compared to prompt pay statues
- Identify top providers with highest rejection rates – EDI team partners with providers to educate

This claim operation metrics are available to senior management on a daily basis to include payment accuracy, prompt pay results, auto-adjudication percentage and EDI rate. The Claims Payment Timeliness Summary is used to monitor and evaluate WellCare's performance in comparison to contractual prompt pay requirements.

Figure 1 in the following page shows a sample of the claims scorecard dashboard.

Figure 1

	Q1			Q2			Q3			Q4		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
Claims Total	3,426,357	3,255,947	3,460,175	3,611,217	4,021,813	3,376,082	3,708,711	3,674,015	3,539,732	3,898,851	3,655,895	39,628,585

	Q1			Q2			Q3			Q4		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
Avg TAT	7.7	7.7	7.3	8.1	8.2	7.9	7.2	7.8	8.6	8.7	7.6	7.5

	Q1			Q2			Q3			Q4		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
EDI Rate	91.9%	91.7%	91.4%	89.6%	91.7%	90.7%	91.2%	91.6%	91.9%	92.2%	92.4%	91.5%

	Q1			Q2			Q3			Q4		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
0 - 10 Days	93.1%	94.1%	92.4%	88.3%	87.6%	87.6%	92.9%	89.5%	94.8%	95.3%	90.8%	91.4%
11 - 20 Days	4.8%	4.6%	5.6%	8.9%	8.0%	9.5%	6.2%	10.2%	4.4%	4.2%	7.8%	6.8%
21 - 30 Days	1.1%	0.6%	1.2%	1.9%	3.5%	2.2%	0.6%	0.7%	0.5%	0.3%	1.2%	1.3%
31+ Days	0.9%	0.7%	0.8%	0.9%	0.9%	0.8%	0.3%	0.2%	0.2%	0.1%	0.4%	0.6%

Contact Center dashboards

The heart of the contact center operation is our Command Center, which provides real-time monitoring of service levels of more than 200 different skills and call types and coordinates action to achieve service level targets. The Command Center features numerous screens that display data and trends including calls in each queue, length of time callers have been waiting to speak to a member services representative and number of member services representatives available to assist callers. The Command Center produces real time data as well as data over time for leadership to track and trend and ensure we are meeting our requirements, and provide a rapid corrective action should a metric fall out of line with requirements. . **Figure 2** in the following page shows a sample of the metrics tracked in our contact center dashboard.

Figure 2

MEMBER
Sample Performance Monitoring/3rd Quarter 2014

	Avg. Speed of Answer		Abandonment Rate %		Service Level		Avg. Hold Time	
	Target	Measure	Target	Measure	Target	Measure	Target	Measure
FL	<30	15	<5%	2%	90%	90%	<3 min	00:00:42
GA		20		4%	80%	82%		00:00:33
HI		13		2%	80%	89%		00:02:10
IL		25		4%	80%	85%		00:01:57
KY		12		4%	80%	89%		00:00:52
MO		7		2%	90%	97%		00:00:25
NJ		9		3%	90%	92%		00:01:10
NY		12		2%	80%	94%		00:01:10
SC		14		2%	80%	89%		00:00:29
TOTAL		15		3%		88%		00:00:50

Quality Improvement Dashboards

One of the ways we enhance our member's health and quality of life is through our comprehensive, systematic and continuous Quality Improvement Program. At WellCare, we have a well-defined QI program that reflects a continuous quality improvement (CQI) philosophy and mode of action. Continuous quality improvement processes identified in the QI program description, work plan and annual evaluation are approved by the applicable committees and conducted to accomplish identified goals. The QI program description defines program structure, accountabilities, scope, responsibilities, and available resources.

The annual QI work plan identifies specific activities and projects to be undertaken by the plan and the performance measures to be evaluated throughout the year. Work plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The annual QI evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate. The annual evaluation describes the overall effectiveness of the QI program by including:

- A description of ongoing and completed QI activities and projects;
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals;
- An analysis of accomplishments in the quality of clinical care and service; and
- Current opportunities for improvement with recommendations for interventions

An example of a template for the QI meeting is attached as **Attachment 114a_Sample QIC Meeting Presentation.** Each Medicaid market has a quarterly QI committee meeting and the metrics are reported through the committee structure.

The attached sample health plan dashboard (**Attachment 114b_Sample Health Plan Dashboard**) is

representative of metrics that are tracked and trended at the health plan level.

Additionally, WellCare also conducts Quarterly Business Reviews (QBRs) with all of the senior management team and several other leaders from across the organization. In these QBR's the team reviews progress on key corporate initiatives, including topics like compliance, care management, quality (QAPIs) and operations for effectiveness and efficiency. This is also includes reviewing for overall profitability, areas of concern, and progress on agreements made with the government partners. In case any area of opportunity is identified, the QBR ensures an executive owner is assigned to that opportunity.

Key Performance Indicator Scorecard

WellCare Market: HEALTH PLAN XX

Time Period: Sep-15

Line of Business: MEDICAID

Financial	Freq	YTD Actual	YTD Budget	Delta (U)/F
Member Months	M	970,000	885,900	84,100
Net Premium PMPM	M	$220.00	$228.24	($8.24)
Net Premium ($000)	M	$220,000	$202,200	$17,800
Total Medical PMPM	M	$200.00	$203.02	$3.02
Rx cost PMPM	M	N/A	N/A	N/A
MBR %	M	88.0%	88.9%	0.95%
% Encounter Data accepted	M	97.0%	97.3%	(0.3%)

Quality	Freq	YTD Actual	YTD Target	Del)/F
HEDIS composite (DOS 2014 reported 2015)	A	29.70	TBD	
CAHPS (DOS 2014 reported 2015)	A	57%	TBD	
% of Mbrs aligned to HPP*	A	30.0	3	%)
High Performance Network (HPN) score	Q	2.1		0.10
% of SF payments linked to Quality Perf	Q	74.0%	5.0%	(1.0%)
HPP Action Plan Progress	Q	99.0%	00.0%	(1.0%)
Geo Access Score	Q	97.0%	98.0%	(1.0%)

People	Freq	YTD Actual	YTD Target	Delta (U)/F
Undesirable Turnover (Annualized)	M	5.0%	9.5%	4.5%
90 Day Turnover (Annualized)	M	0.5%	1.5%	1.0%
HiPer Retention	M	100.0%	95.0%	5.0%
AOS - Company Overall	A	80.0%	75.0%	5.0%
AOS - Engagement	A	75.0%	75.0%	0.0%

Medical Cost Management	Freq	YTD Actual	YTD Budget	Delta (U)/F
Admits/K (Auths)	M	107.00	110.00	3.00
ER Visits/K	M	740.00	735.00	(5.00)
30-day Readmit rate	M	4.20%	4.30%	0.10%
% Auto Approved (In Patient/MedSurg)	M	4.0%	7.0%	3.0%
Unit Cost Facility	Q	155.0%		
Unit Cost Provider	Q	114.0%		
% Members	M	0.2%	0.2%	0.0%
Market ME $000) Savings	M	$1,000	$1,100	($100)
Co rate M 000) Savings	M	$1,250	$1,204	$46

Membership/Sales	Freq	YTD Actual	YTD Budget	Delta (U)/F
Membership	M	110,000	98,200	11,800
Market Share	M	24.0%	25.0%	(1.0%)
Disenrollment rate	M	(3.0%)	(4.0%)	1.0%

Regulatory / Compliance	Freq	YTD Actual	YTD Target	Delta (U)/F
Compliance Score	Q	95%	90%	5.0%
Timeliness of reporting	M	99%	100%	(1.0%)
# of non compliant report events	M	0		

SAMPLE

* Actual reflects prior year baseline; see appendix for more detail

Medical Cost Management Notes:

Medicaid Admits/K Targets are still being finalized at this time

ER visits are heavily weighted with IBNR in early months due to claim lag

Admits/K, 30-day readmit rate and auto approval based on auth data using admit date

Unit Cost facility actuals based on Oct'13-Sep'14 claims data (pulled Nov 2014)

Unit Cost Provider actuals based on Jan - Dec '14 clams data (pulled Jan 2015)

Admits per 1000 calculations are based on 365 days

ER visitsper 1000 calculations are based on 12 months

Auth types:

DAA auth type - INP (exclude birth and NICU)

Admits auth type - 'INP','SNF','BRH','BHI','BHD','BHR','LTA','LTC','INR','BHS'

30-day re-admit auth type -INP (include birth and NICU)

Items highlighted in orange are an annualized projection

APPENDIX

SAMPLE

Financial		
Metric	Freq	Notes
Member Months	M	Cumulative membership
Premium PMPM	M	Premium per member per month; Excluding premium taxes and Excluding ACA Medicaid revenue
Net Premium ($000)	M	Excluding premium taxes and Excluding ACA Medicaid revenue
Total Medical PMPM	M	Medical cost per member per month
Rx cost PMPM	M	Prescription drug cost per member per month
MBR %	M	Medical benefits ratio excluding premium taxes and ACA Medicaid revenue
RAPS $	M	Incremental revenue attributable to accurate capture of members' complete health status
% Encounter Data accepted	M	Percent of paid claims accepted by the State/CMS divided by total paid claims

Membership/Sales		
Metric	Freq	Notes
Membership	M	Number of member[illegible]d
Cost / sale	M	Acquisition c[illegible]per [illegible]roll[illegible]
Disenrollment rate	M	Per[illegible]ntage o[illegible]mbe[illegible]enroll[illegible]
CCP Prod/BC	M	Nu[illegible] of sa[illegible]s [illegible]odu[illegible]d per W2 agent
W2 sales	M	Num[illegible]er [illegible]e[illegible]ollm[illegible]nts through the W2 channel
1099 sales	M	[illegible]umb[illegible] of [illegible]ollments through the 1099 channel
DTC sales	M	[illegible]mbe[illegible] of enrollments through the "Direct to Consumer" channel
Market Share (Medicaid only)	M	December market share will be used as the 2015 budget

SAMPLE

People		
Metric	Freq	Notes
Undesirable Turnover	M	Excludes DM and PM performance ratings (includes CE,FE, ME and no rating), Attrition count includes Voluntary and Pending reason codes
90 Day Turnover	M	Associates terminated in first 90 days of employment with any reason code
HiPer Retention	M	Percentage of associates rated CE or FE, as part of the 2014 Annual Review process, remaining at the end of 2015. The metric takes the count of all HiPers remaining at the end of the reporting period and divides by the total HiPers (as determined in the 2014 Annual Review process). For example if we have 100 HiPers and 2 quit this month next month we will report 98/100 = 98% HiPer retention.
AOS - Company Overall	A	Aggregate results of Company Overall theme within the AOS survey. Made up of the following questions; - I am proud to tell people I work for WellCare. - I have confidence in the future of WellCare. - I am NOT considering leaving WellCare within the next 12 months. - I have a high level of satisfaction with WellCare at the present time

AOS - Engagement	A	Aggregate results of Engagement theme within the AOS survey. Made up of the following questions: - Associates are encouraged to participate in making decisions that affect their work. - I love what I am doing at WellCare. - I feel appreciated and valued. - I can adjust my work schedule and/or work arrangements to meet my needs. - I have a great balance between work and my personal life. - We have great teamwork-people pull together. - My manager stands up and supports me. - My goals / performance expectations are clear and know what it takes to be successful here. - My job capitalizes on my strengths and capabilities. - I would recommend WellCare to a friend as a good place to work.

Medical Cost Management		
Metric	Freq	Notes
Total Admits/K (Auths)	M	The Medicaid Inpatient budget includes MedSurg, Birth, NICU, BH, SNF, LTC, Other; The Medicare Inpatient budget includes MedSurg, BH, SNF, LTC, Other; Budget is based on best possible estimation of auth equivalent of Actuary claims utilization targets
ER Visits / K	M	ER Visits including IBNR; claims based more recent periods will include a majority of IBNR due to claim lag
30 Day Readmit Rate	M	This target was set overall (product level on limitation defined as including MedSurg/Births/NICU and allocated down to LOB level
% Auto Approved (In Patient/MedSurg)	M	Global Target by Care (specific target
Unit Cost Facility	Q	% of Medicaid Base on most recent contract analysis date: DOS 10/01/2013 and 9/30/2014;There is not an established target at this time, needs to be developed
Unit Cost Provider	Q	Based on most recent contract analysis date: DOS 1/1/2014 - 9/30/2014; There is not an established target at this time, needs to be developed
% Trgt Members in CM	M	Managed: Member has an Assessment and Care Plan during the program duration
Market MEI ($000) Savings	A	Savings incurred by Market Investment on Medical Expense Initiative net of service fund
Corporate MEI ($000) Savings	M	Savings incurred by Corporate Investment on Medical Expense Initiative net of service fund

Quality Medicaid		
Metric	Freq	Notes
HEDIS composite	A	Average Percentile for LTI Measures a. Baseline on the 10 LTI measures identified in the market. The measures will vary by state. b. Based on reported measures (hybrid, if applicable) that have a benchmarked published in the Quality Compass for the applicable reporting year. c. The Current Budget YTD represents HEDIS 2014 final rates and 2014 Quality Compass thresholds for 2017 LTI Measures. d. The Actual YTD will be available in fall 2015 based on HEDIS 2015 and 2015 Quality Compass; Current score to be used until 2015 score is available
CAHPS	A	Percentage of Accreditation CAHPS measures at or above the 50th percentile. a. Based on latest Accreditation Standards b. The Current Budget YTD is based on CAHPS 2014 and 2014 Benchmarks and Thresholds c. The YTD Actual will be available in fall 2015 based on CAHPS 2015 and 2015 Benchmarks and Thresholds; Current score to be used until 2015 score is available

SAMPLE

% of Mbrs aligned to HPP	A	% of Members in a LOB (e.g. Florida Medicare) assigned to a practice designated as "High Performing". High Performing status is determined by a combination of Quality and Cost Efficiency performance. Quality performance is based on a composite of practice-level HEDIS measures (Administrative data only), converted to a 1 – 5 scale. Cost Efficiency performance is based on practice-level MBR%. Practices are assigned a letter grade (A – D) for each of Quality and Cost Efficiency, which are then averaged (equally weighted) to determine an Overall Grade. In cases of one degree of separation, the Quality Grade breaks the tie. Practices with Overall Grades of A or B are considered to be "High Performing"
% of SF payments linked to Quality Perf	Q	% of 2014 Shared Savings (Service Fund) bonus paid to providers that are explicitly linked to Quality performance standards. [Note: Denominator will also include administrative PMPM payments not related to specific Administrative services, such as Credentialing]
High Performance Network (HPN) score	Q	Composite score assessing the overall performance of a State's provider network on a 1 – 5 rating scale (separate ratings for Medicare and Medicaid). Based on a weighted average roll-up of 14 distinct measures across the areas of Access & Availability, Quality, and Operational efficiency
Geo Access Score	Q	% of county/specialty combinations that are passing the access standard
HPP Action Plan Progress	Q	% of members assigned to on-track Practice-level HPP Action Plans as a % of total Target improvement in % of Members Aligned to HPPs KPI. [Note: Intent is to ensure that (1) sufficient Practice-level Action Plans are underway to achieve % of Members Aligned to HPP KPI and (2) these Action Plans are on-track]

SAMPLE

Regulatory / Compliance		
Metric	Freq	Notes
Compliance Score	Q	Market Compliance Oversight Quarterly Performance Report (the "Quarterly Performance Report") assesses each Market's adherence with the Compliance Program through the monitoring of: • Structure: Program oversight; standards, policies and procedures; reporting mechanisms; compliance training and education; and communication and awareness strategy • Process: Assessment, identification and prioritization of compliance risks; prevention, detection and monitoring of key risk areas; response and correction of key risk areas; external regulatory and internal policy implementation; corrective action and internal action plans; and enforcement and disciplinary Guidelines • Outcomes: Compliance audit results; regulatory compliance results, e.g., notices, fines, and penalties); regulatory reporting; privacy and security; delegated entity compliance; and Associate Opinion Survey – Ethics and Compliance
Timeliness of reporting	M	Report submitted on time to regulator and loaded into LIONS
# of non compliant report events	M	Report past due, submitted late to regulator or not loaded into LIONS

SECTION IV.T REPORTING AND DELIVERABLES

115. Provide examples of the following reports:

- Member Grievance System
- Performance Improvement Projects
- Care Management

How will the MCO use required reports in its day to day management and operations?

OUR REPORTS AND USAGE IN DAILY OPERATIONS AND MANAGEMENT

WellCare has a long history of ensuring accuracy and completeness of all reports with our government partners. We will build on our successful record of complying with the reporting requirements of multiple governmental agencies at both state and federal level. WellCare has reviewed and acknowledged the requirements as outlined in *Section T- Reporting and Deliverables* of the Request for Proposals. Reports will be developed in accordance with MLTC requirements and state and federal reporting guidelines. Our timeframe of the report submission supports the requirements outlined in *Attachment 38 – Revised Reporting Requirements.* We will maintain a Nebraska-specific reporting policy to submit required reports and submissions timely and in the appropriate format as prescribed by MLTC. We also have local staff members who have dedicated responsibility to ensure reports are submitted on time and in the proper formats.

WellCare Reporting Capabilities

- Industry leading process to ensure accuracy and compliance
- Flexibility to provide reports on demand

Member Grievance System Reporting

WellCare uses data from grievances to evaluate trends and develop insights that can be applied to operational improvements (or to help measure the effectiveness of improvement activities that have been implemented). Our grievance database and, our internal, proprietary applications, support the grievance process by tracking member and provider grievances from receipt to resolution. This affords us the means to address not only issues affecting individual member satisfaction, but to identify potential trends in the delivery system as a whole, permitting WellCare staff to take prompt, corrective steps to minimize risks to performance standards.

All grievances captured in the databases are categorized to help easily identify trends and opportunities for improvement. Through the databases, we use routine and ad hoc reports to monitor activity, identify trends, and evaluate opportunities to improve service or quality. Management reports are produced on a daily basis to evaluate staff performance, state compliance of all timeframes for acknowledgment and resolution are met, and aging of open cases. Using this data, we continuously assess resources and caseloads to minimize risk to performance standards. On a monthly basis, we evaluate the number of grievances received, the percent resolved within required timeframes and the nature of the requests. Data is aggregated on a quarterly basis to identify trends. For example, reviewing our top grievance category drivers, allows us to develop insights into how we can improve member and provider satisfaction by improving communications and/or process'. Ad hoc reports are produced to evaluate potential opportunities for improvement such as provider-specific trends or outliers. As opportunities are identified, we initiate an in-depth review of the process and develop action plans with the necessary departments who can address needed changes. Action plans are shared with the Utilization Management Committee

(UMC) and Quality Improvement Committees (QIC) as appropriate. Reports of activities of the grievance department are also presented in the Customer Service Quality Improvement Workgroup (CSQIW).

Our QIC provides general direction and oversight for member grievance surveys and provides recommendations for improvement, requesting corrective action and providing approval where necessary and appropriate. An example of our Member Grievance report is attached in **Attachment 115a_Member Grievance Report.**

The Member Grievance Report provides a summary of the following (as depicted in **Figure 3**):

- The number, type, and resolution of member grievances
- Percent of grivances resolved within the required timeframe
- Trends or problem areas and activities to improve member satisfaction
- The member grievance category driver for a particular quarter. For example, in the second quarter of 2015, we observed the following categories in our Kentucky plan:
  - Billing/Claims (297) – Member dissatisfaction with participating providers billing for services not covered by the plan
  - Physician (35) - Issues regarding rude treatment from the participating provider, specialist, and/or staff, appointment availability, difficulty obtaining medical records, etc.
  - Health Plan (48) - Member dissatisfaction with the plan's processes or the plan's staff

Figure 3

Quarter	Grievances Received	Grievances Closed	% Closed within Compliance
Q2 2014	444	512	100%
Q3 2014	406	442	99.3%
Q4 2014	347	332	99%
Q1 2015	474	421	99%
Q2 2015	446	484	99%

Performance Improvement Projects Reporting

Annually, WellCare will conduct population and demographic studies in Nebraska to identify high utilization diagnostic categories, high risk conditions, opportunities to improve coordination of medical care across settings or transitions of care, collaboration between medical care and behavioral healthcare, or areas of potential health care disparities within the population. This study will be presented to the Quality Improvement (QI) team to analyze and determine relevant and meaningful opportunities within the population. The recommendations of the QI team will be presented to the UMC and/or QIC for approval and oversight.

Once the QI committees have identified areas of opportunity, monitoring of the specific quality indicator will occur through measurement based on scientific methodology. Performance improvement projects shall address the following elements:

- A correctly identified study population
- Valid sampling techniques (if not using entire eligible population)
- Accurate/complete data collection

- Appropriate improvement strategies
- Data analysis and interpretation
- Identification and prioritization of opportunities for improvement
- Reported improvements (if any) and
- Sustained improvement over time (if any).

Results of the Performance Improvement Projects will be presented to the QI team, with the analysis and recommendation of further action to be taken presented to the UMC and the QIC. Root cause, barrier analysis and recommendations for changes and/or modifications of methodology will be solicited at these meetings. The workgroup will also be responsible for assessing whether activities are being completed in a timely basis or if a revision in interventional methodologies is required.

The action plans for interventions will be developed by the QI team and presented to the UMC and the QIC for discussion and feedback. The general topic of discussion includes:

- Development of interventional methodologies
- Tracking and trending results over time
- Root cause and barrier analysis
- Results will be presented to all quality committees, and interventions will be re-evaluated and opportunities for continued improvement will be identified.
- Results will be sent to appropriate regulating bodies as required.

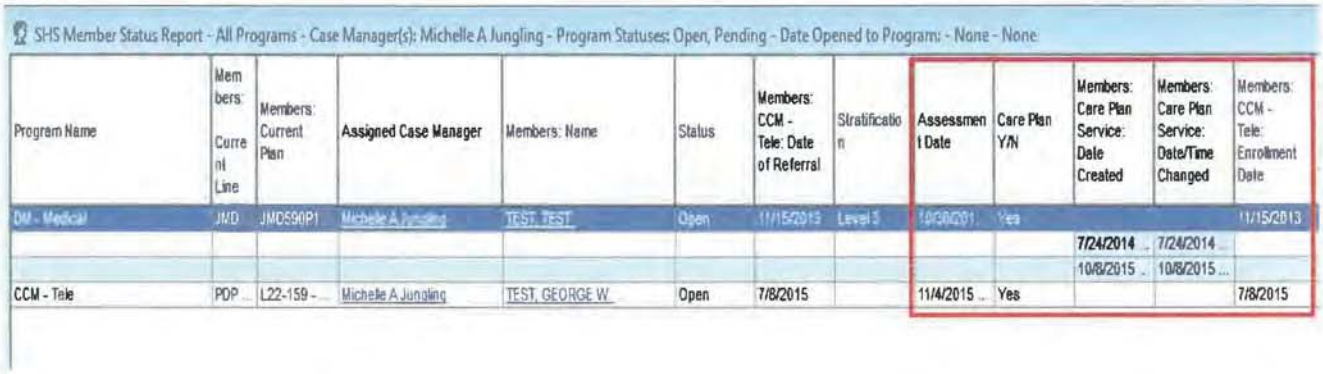
Performance Improvement Projects (PIPs) are WellCare's key tools for achieving the goals outlined in our quality strategy. We conduct PIPs to assess and improve the quality of a targeted area of clinical or non-clinical care or services provided to members. PIP reports provide the framework for monitoring, measuring, and improving the delivery of health care for members in day to day operations. Once interventions, improvement strategies, and ongoing initiatives have been implemented in response to a PIP, they become part of the daily Quality improvement process.

An example of PIPs report is attached in **Attachment 115b_PIPs Report.**

Care Management Reporting

WellCare utilizes reporting to measure effectiveness of programs, productivity and member outcomes. Records are reviewed regularly to ensure compliance with various requirements such as member outreach, updating of care plan, and staffing ratios (as shown in Figure 2). Managers are able to identify training gaps or needs through review of this documentation; ensuring members are progressing towards care plan goals. In addition to reviewing daily caseload reports, clinical leadership and our health services training specialist generate monthly and quarterly reports to monitor performance, including but not limited to the number of assessments and care plans completed within required timelines, case file and clinical documentation. Our Medical Management Platform (MMP) allows for real-time reporting; providing managers reports such as caseload ratios, overdue assessments, contact frequency and care plan completion/updates. Reports may be at the individual case manager level, rolled-up by manager or aggregated for the entire department for senior leadership.

Figure 4: Member Status Report



SHS Member Status Report - All Programs - Case Manager(s): Michelle A Jungling - Program Statuses: Open, Pending - Date Opened to Program: - None - None

Program Name	Members: Current Line	Members: Current Plan	Assigned Case Manager	Members: Name	Status	Members: CCM - Tele: Date of Referral	Stratification	Assessment Date	Care Plan Y/N	Members: Care Plan Service: Date Created	Members: Care Plan Service: Date/Time Changed	Members: CCM - Tele: Enrollment Date
DM - Medical	JMD	JMD590P1	Michelle A Jungling	TEST, TEST	Open	11/15/2013	Level 3	10/30/201	Yes			11/15/2013
										7/24/2014 ..	7/24/2014 ...	
										10/8/2015 ..	10/8/2015 ...	
CCM - Tele	PDP ...	L22-159 - ...	Michelle A Jungling	TEST, GEORGE W	Open	7/8/2015		11/4/2015 ..	Yes			7/8/2015

Quarterly reports include member satisfaction with the care management program, readmission rates and number of members enrolled in care management programs. This information is then analyzed and brought to the QIC and the Chief Medical Officer for discussion of the effectiveness of past initiatives and creation of any new processes needed to improve outcomes.

An example of the Care Management report is attached in **Attachment 115c_Care Management Report.**

A. Member and Provider Satisfaction
ii. Grievances

WellCare

Member Grievances Q2

Goals:

- Report the number, type, and resolution of member grievance
- Resolve 95% of grievances within compliance
- Identify trends or problem areas and implement activities to improve member satisfaction

Quarter	Grievances Received	Grievances Closed	% Closed within Compliance
Q2 2014	444	512	100%
Q3 2014	406	442	99.3%
Q4 2014	347	332	99%
Q1 2015	474	421	99%
Q2 2015	446	484	99%

A. Member and Provider Satisfaction
ii. Grievances

The top 3 member grievance category drivers for Q2 2015 were:

Category	Definition/Example
Billing/Claims (297)	Member's dissatisfaction with Par Providers billing for services not covered by the Plan
Physician (35)	Issues regarding rude treatment from the participating provider, specialist, and/or staff, appointment availability, difficulty obtaining medical records, etc.
Health Plan (48)	Member's dissatisfaction with the Plan's processes or the Plan's staff

Barriers include:

- Providers not reviewing eligibility
- Members providing incorrect insurance information or not providing insurance information to providers
- Members not reviewing their plan materials
- Inconsistent information given to members by the Plan

A. Member & Provider Satisfaction
ii. Grievances

WellCare

Provider Grievance Goals:

- Report the number, type, and resolution of provider grievances
- Resolve 95% of grievances within compliance
- Identify trends or problem areas and implement activities to improve provider satisfaction

Quarter	Provider Grievances Received
Q2 2014	2
Q3 2014	7
Q4 2014	2
Q1 2015	0
Q2 2015	2

B. Quality of Care Issues

Goals:

- Monitor the number of QOC cases received for investigation, cases resolved, and implemented provider corrective action.
- Monitor QOC cases by provider and diagnosis to identify trends and implement activities to decrease trends as appropriate.

Quality of Care Issues – Q2 2015	
New Cases Referred	**133**
Medicare	0
Medicaid	133
Closed Cases	**33**
Substantiated	24
Unsubstantiated	9

Closed Case Resolution Status	
No Further Action	33
Track and Trend	0

There were no identifiable trends

Health Plan Performance Improvement Project (PIP)

WellCare of Kentucky

Antipsychotic Medication Use in Children & Adolescents 2014 – 2017[1]

Project Phase: ☐ **Proposal** ☒ **Baseline** ☐ **Interim** ☐ **Final**

Submission Date: September 1, 2015

Submission to: Commonwealth of Kentucky Department for Medicaid Services

[1]Insert project initiation and completion dates

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MCO AND PROJECT IDENTIFIERS

Please complete all fields as accurately and as completely as possible.

1. Name of MCO: WellCare of Kentucky

2. Select the Report Submission:
[If any change from initial submission, please complete section 7 below.]

☐ PIP Part I: Project Proposal Date submitted: **9/1/2014**

☒ PIP Part II: Baseline Report Date submitted: **9/1/2015**

☐ PIP Part III: Interim Report Date submitted:

☐ PIP Part IV: Final Report Date submitted:

3. Contract Year:

4. Principal Contact Person: Ronda Roberts
[Person responsible for completing this report]

4a. Title: Senior Director, Quality Improvement

4b. Phone: 502-253-5139 ext.

4c. Email Address: ronda.roberts@wellcare.com

5. Title of Project: Antipsychotic Medication Use in Children & Adolescents

6. External Collaborators (if any):

7. For Final Reports Only: If Applicable, Report All Changes from Initial Proposal Submission:
[Examples include: added a new survey, change in indicator methodology or data collection, deviated from HEDIS® specifications, reduced sample size(s).]

8. Attestation

The undersigned approve this PIP Proposal and assure their involvement in the PIP throughout the course of the project.

Medical Director	Date
Quality Director	Date
Information Systems Director (when applicable)	Date
CEO	Date

PIP Title:
DMS PIP Proposal Approval Date

DMS Staff Signature _____

DMS Staff Title

DMS Comments (if applicable):

Abstract

This section should be approximately 1-2 pages in length. The Abstract should be completed only for the Final Report.

[Provide an abstract of the PIP highlighting the project topic and objectives, briefly describe the methodology and interventions, and summarize results and major conclusions of the project.][2]

1. Project Topic / Rationale / Aims

[Provide title of the project; rationale for the project, aim(s), objective(s), study question(s), baseline and/or benchmark data, and goal for improvement.]

2. Methodology

[Describe the population, study indicators, sampling method, baseline and remeasurement periods, and data collection procedures.]

3. Interventions

[Describe the interventions and interventions target(s). This section may include interim results gleaned from using a PDSA method, if applicable.]

4. Results

[Specify number of cases in the project, baseline and remeasurement rates for project indicators, and statistical test results if applicable.]

5. Conclusions

[Address whether the project objectives were met, any corresponding explanations, a synthesis of the major project findings, any major project limitations, barriers, financial impact and next steps.]

[2] Delete instructions in brackets [ ] when fields are completed.

Project Topic

Provide a general description of the project topic that is clearly stated and relevant to the enrolled population.

1. Describe Project Topic

The project topic for this collaborative Performance Improvement Project (PIP), chosen by the Kentucky Department for Medicaid Services (DMS), is Antipsychotic Medication Use in Children and Adolescents. A recent national study, examining the relationship of mental health diagnosis and treatment with second generation antipsychotics over time in Medicaid-enrolled children, found a 62 percent increase from 2002 to 2007 in the prescribing of atypical antipsychotics.[1]

2. Rationale for Topic Selection

The project topic that DMS has chosen for this collaborative PIP is Antipsychotic Medication Use in Children and Adolescents. Recent studies suggest not only an increase in the frequency of prescribing antipsychotic medications in youth, but also an increase in duration of use.[2] One study, conducted by Cooper et al. (2006) reported an increase of antipsychotic prescriptions from 8.6 per 1,000 children in 1996 to 39.4 per 1,000 children in 2002.[3] Additionally, data collected in 2007 suggest that an average of 8.9 percent of youth, across 16 state Medicaid programs, were prescribed doses of antipsychotic medication exceeding the recommended doses, despite the lack of evidence suggesting that higher doses are associated with better response.[4,5]

According to a recent systematic review, conducted by Toteja et al. (2013), approximately 9.6 percent of youth were prescribed multiple concurrent antipsychotics even though evidenced-based practice guidelines caution against the use of multiple concurrent antipsychotics in children.[6,7,8] Evidence suggests that the use of antipsychotics in children can increase the child's risk for certain serious health complications, including weight gain, diabetes, liver toxicity, and cardiac arrhythmias, just to name a few.[9,10,11,12] As such, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends psychosocial care as the first-line of treatment, prior to the initiation of an antipsychotic, particularly in the absence of an FDA indication for use of an antipsychotic.[13] Additionally, follow-up care is identified as one of the core principles of prescribing by the AACAP, including the development of a plan by the prescriber to monitor the patient, short and long term.[13] However, despite these evidence-based standards of care, one study indicated that nearly a third of Medicaid-enrolled children and youth, who were prescribed an antipsychotic, did not receive concurrent psychosocial therapy.[14]

Analysis of WellCare of Kentucky data for Calendar Year (CY) 2013 indicates that there were 214,906 Medicaid members, ages zero to seventeen. Of those members, 14.54 percent (n=31,256 of 214,906) had at least one behavioral health diagnosis, and 1.95 percent (n=4,188 of 214,906) had at least one prescription for an antipsychotic medication. Data within each of these categories is further stratified by age, sex, race, Medicaid Line of Business, and Region (Please see Table 1).

Table 1: 2013 Demographic Stratifications within Categories: Overall Medicaid Members Ages 0-17, Members with ≥ 1 Behavioral Health (BH) Diagnosis (Dx), Members with ≥ 1 Antipsychotic (AP) Prescription (Rx)

	Medicaid Members 0-17	%	Members with ≥ 1 BH Dx	%	Members with ≥ 1 AP Rx	%
	N=214906		N=31256		N=4188	
AGE						
0 TO 5	73716	34.30%	2139	6.84%	33	0.79%
6 TO 11	76836	35.75%	14068	45.01%	1514	36.15%
12 TO 17	64354	29.95%	15049	48.15%	2641	63.06%
SEX						
Male	110752	51.54%	19238	61.55%	2894	69.10%
Female	104153	48.46%	12018	38.45%	1294	30.90%
Unknown	1	0.00%				
Race						
White	169036	78.66%	22955	73.44%	2507	59.86%
Black	19052	8.87%	2217	7.09%	287	6.85%
Other	13677	6.36%	1399	4.48%	133	3.18%
Unknown	11218	5.22%	4588	14.68%	1253	29.92%
Asian	1190	0.55%	53	0.17%	4	0.10%
American Indian	558	0.26%	31	0.10%	3	0.07%
Hawaiian	175	0.08%	13	0.04%	1	0.02%
Line of Business						
KMD	196731	91.54%	22832	73.05%	1865	44.53%
KAB	12130	5.64%	5911	18.91%	1569	37.46%
KHK	6045	2.81%	2513	8.04%	754	18.00%
Region						
Region 1	13713	6.38%	2221	7.11%	354	8.45%
Region 2	21690	10.09%	3545	11.34%	658	15.71%
Region 3	20793	9.68%	2325	7.44%	330	7.88%
Region 4	30204	14.05%	4041	12.93%	543	12.97%
Region 5	42897	19.96%	5832	18.66%	797	19.03%
Region 6	17468	8.13%	2730	8.73%	446	10.65%
Region 7	19723	9.18%	3215	10.29%	410	9.79%
Region 8	48418	22.53%	7347	23.51%	650	15.52%

Stratified rates of Antipsychotic Use in proportion to the total overall Medicaid population, ages 0-17, are presented in Table 2. According to this data, antipsychotic medication use rates increased with age and male Medicaid recipients (ages 0-17) were more than twice as likely as female recipients to be prescribed an antipsychotic medication (2.61 percent vs. 1.24 percent). Antipsychotic use rates varied between races, with the largest proportion identified as "Unknown". Members enrolled in the KAB (Kentucky Aged, Blind, and Disabled) Medicaid Line of Business had the highest rate of use at 12.93 percent, followed closely by KHK foster care members at 12.47 percent, and lastly by traditional Medicaid recipients (KMD) with a 0.95 percent rate of use.

Regional rates varied among members, with members in Region Two representing the greatest proportion of members with an antipsychotic prescription, relative to the general overall population, at 3.03 percent. (Please see Appendix A for a complete listing of counties in each region and a corresponding map of Kentucky regions).

Table 2: 2013 Stratified Antipsychotic Use Rates in Proportion to the Overall Population

	Medicaid Members 0-17	Members with ≥ 1 AP Rx	%
	N=214906	N=4188	1.95%
AGE			
0 TO 5	73716	33	0.04%
6 TO 11	76836	1514	1.97%
12 TO 17	64354	2641	4.10%
SEX			
Male	110752	2894	2.61%
Female	104153	1294	1.24%
Unknown	1		
Race			
White	169036	2507	1.48%
Black	19052	287	1.51%
Other	13677	133	0.97%
Unknown	11218	1253	11.17%
Asian	1190	4	0.34%
American Indian	558	3	0.54%
Hawaiian	175	1	0.57%
Line of Business			
KMD	196731	1865	0.95%
KAB	12130	1569	12.93%
KHK	6045	754	12.47%
Region			
Region 1	13713	354	2.58%
Region 2	21690	658	3.03%
Region 3	20793	330	1.59%
Region 4	30204	543	1.80%
Region 5	42897	797	1.86%
Region 6	17468	446	2.55%
Region 7	19723	410	2.08%
Region 8	48418	650	1.34%

Prevalence rates for behavioral health (BH) diagnoses in proportion to the total overall Medicaid population, ages 0-17, are presented in Table 3. According to this data, rates of BH diagnosis increased with age and male Medicaid recipients (ages 0-17) were more likely than female recipients to receive at least one behavioral health diagnosis in 2013 (17.37 percent vs. 11.54 percent). Prevalence of BH diagnosis varied between races, with the largest proportion identified

as "Unknown". Members enrolled in the KAB (Kentucky Aged, Blind, and Disabled) Medicaid Line of Business had the highest rate of BH diagnosis at 48.73 percent, followed by KHK foster care members at 41.57 percent, and lastly by traditional Medicaid recipients (KMD) with an 11.61 percent rate of diagnosis. Regional rates varied among members, with members in Region Two representing the greatest proportion of members with a BH diagnosis, relative to the general overall population, at 16.34 percent. (Please see Appendix A for a complete listing of counties in each region and a corresponding map of Kentucky regions).

Table 3: 2013 Behavioral Health Diagnoses Prevalence Rates in Proportion to the Overall Population

	Medicaid Members 0-17	Members with ≥ 1 BH Dx	%
	N=214906	N=31256	14.54%
AGE			
0 TO 5	73716	2139	2.90%
6 TO 11	76836	14068	18.31%
12 TO 17	64354	15049	23.38%
SEX			
Male	110752	19238	17.37%
Female	104153	12018	11.54%
Unknown	1		
Race			
White	169036	22955	13.58%
Black	19052	2217	11.64%
Other	13677	1399	10.23%
Unknown	11218	4588	40.90%
Asian	1190	53	4.45%
American Indian	558	31	5.56%
Hawaiian	175	13	7.43%
Line of Business			
KMD	196731	22832	11.61%
KAB	12130	5911	48.73%
KHK	6045	2513	41.57%
Region			
Region 1	13713	2221	16.20%
Region 2	21690	3545	16.34%
Region 3	20793	2325	11.18%
Region 4	30204	4041	13.38%
Region 5	42897	5832	13.60%
Region 6	17468	2730	15.63%
Region 7	19723	3215	16.30%
Region 8	48418	7347	15.17%

WellCare of Kentucky further assessed data for 2013 for the prevalence of antipsychotic prescriptions amongst members who had a least one behavioral health diagnosis in the measurement year (Table 4). Additionally, data was assessed for the proportion of members who were prescribed an antipsychotic medication but did not have a behavioral health diagnosis in the same year. According to this data, there were 31,265 members, ages 0-17, who had at least one behavioral health diagnosis in 2013. Of those members, 3,997 (12.79 percent) were prescribed at least one antipsychotic medication in the same year. Conversely, there were 4,188 total members with at least one antipsychotic prescription in 2013. Of those members, 197 (4.56 percent) did not have a behavioral health diagnosis, according to claims data, at any time in the same year.

Table 4: Prevalence of Behavioral Health Diagnosis Among Members with an Antipsychotic Prescription

	Members 0-17 with BH Dx	%
Members with AP Rx	3997	12.79%
Members without AP Rx	27259	87.21%
Total	31265	100%
	Members 0-17 with AP Rx	%
Members with BH Dx	3997	95.44%
Members without BH Dx	197	4.56%
Total	4188	100%

WellCare of Kentucky conducted additional analysis of CY 2013 pharmacy data regarding prescriber practices. This data was based on paid claims for filled antipsychotic medication prescriptions in the CY for members, ages 0-17. Data was filtered, based on max fill date for prescriptions by members, associated with unique prescribers. Therefore, if the prescriber varied from month to month for a single medication per member, this was reflected in the data. Max fill date is defined as the most recent fill date for a unique Antipsychotic Medication in the CY. Data (Table 5) is stratified by Provider Type and Provider Specialty. Provider Types and Specialties were determined via the KY State File Roster of Providers.

Table 5: 2013 Prescriber Types and Specialties for Antipsychotic Medications for Members ages 0-17.

	Frequency of Prescriber Type/Specialty	%
Physician	**5294**	**78.01%**
Psychiatrist	2379	35.06%
General Practitioner	2139	31.52%
General Pediatrician	504	7.43%
Internist	114	1.68%
Physical Medicine and Rehabilitation Practitioner	82	1.21%
Family Practitioner	39	0.57%
Neurologist	13	0.19%
Anesthesiologist	10	0.15%
Osteopathy	4	0.06%
General Surgeon	3	0.04%
Geriatric Practitioner	2	0.03%
Plastic Surgeon	1	0.01%
Emergency Medicine Practitioner	1	0.01%
Urologist	1	0.01%
Opthamologist	1	0.01%
Obstetrician/Gynecologist	1	0.01%
Advanced Registered Nurse Practitioner	**1325**	**19.53%**
Nurse Practitioner (Other)	1117	16.46%
Family Nurse Practitioner	146	2.15%
Psychiatric Nurse Practitioner	44	0.65%
Pediatric Nurse Practitioner	17	0.25%
Multi-Specialty Group-Nurse Practitioner	1	0.01%
Physician Assistant	**110**	**1.62%**
Other	**57**	**0.84%**
Grand Total	**6786**	**100.00%**

3. Aim Statement, Objectives, Study Question and Goal

WellCare of Kentucky aims to improve safe and judicious antipsychotic use in children and adolescents.

This project is designed to answer the following questions:

- Do robust interventions aimed at improving Plan, provider, and member performance decrease the percentage of children and adolescents one to 17 years of age who were on two or more antipsychotic medications?
- Do robust interventions aimed at improving Plan, provider, and member performance increase the percentage of children and adolescents one to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment?
- Do robust interventions aimed at improving Plan, provider, and member performance increase the percentage of children and adolescents one to 17 years of age who had a new prescription for an antipsychotic medication and had metabolic monitoring?
- Do robust interventions aimed at improving Plan, provider, and member performance decrease the percentage of children and adolescents zero to 17 years of age who were on antipsychotic medication and who received two or more antipsychotic medication prescriptions with higher-than-recommended doses?
- Do robust interventions aimed at improving Plan, provider, and member performance increase the percentage of children and adolescents zero to 17 years of age who had a new prescription for an antipsychotic medication and had one or more follow-up visits with a prescriber?
- Do robust interventions aimed at improving Plan, provider, and member performance increase the percentage of children and adolescents zero to 17 years of age who had a new prescription for an antipsychotic medication and had baseline metabolic screening?

This project seeks to achieve the following objectives:

- Decrease HEDIS® rates for Use of Multiple Concurrent Antipsychotics in Children and Adolescents to 6.0 percent over a three year time period.
- Increase HEDIS® rates for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics to 48.2 percent over a three year period.
- Increase HEDIS® rates for Metabolic Monitoring for Children and Adolescents on Antipsychotics to 18.5 percent over a three year period.
- Decrease rates for Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents to 7.9 percent over a three year time period.
- Increase rates for Follow-up Visit for Children and Adolescents on Antipsychotics to 72.8 percent over a three year period.
- Increase rates for Metabolic Screening for Children and Adolescents Newly on Antipsychotics to 6.0 percent over a three year period.

HEDIS® 2015 Technical Specifications will be used to measure baseline data for the following measures: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC), Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM). Data for the following three measures will be collected according to the technical specifications outlined in the "Draft Document for HEDIS 2015 Public Comment": Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents, Follow-up Visit for Children and Adolescents on Antipsychotics, Metabolic Screening for Children and Adolescents Newly on Antipsychotics. Performance targets for all measures were determined based on NCQA field testing data for each measure, and are detailed in the "Gaps in Care" sections for each Measure Work-Up, also included in the "Draft

Document for HEDIS 2015 Public Comment". Goals may be revised based on baseline rates so that meaningful improvement over baseline rates is targeted.

Methodology

The methodology section describes how the data for the project are obtained.

1. Performance Indicators

The following measures will be utilized to measure performance for this project:

1. Decrease HEDIS rate for Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

   Data for this measure will be collected according to HEDIS® 2015 Technical Specifications for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)* (Appendix B) and will include the calculation of the following rate:

   The percentage of children and adolescents, 1-17 years of age who were on two or more concurrent antipsychotic medications.

2. Increase HEDIS rate for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

   Data for this measure will be collected according to HEDIS® 2015 Technical Specifications for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)* (Appendix B) and will include the calculation of the following rate:

   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.

3. Increase HEDIS rate for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).

   Data for this measure will be collected according to HEDIS® 2015 Technical Specifications for *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)* (Appendix B) and will include the calculation of the following rate:

   The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

   *Please see Appendix B for the complete HEDIS® 2015 Technical Specifications for these measures.

4. Decrease the rate for the Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents, as defined by the "Draft Document for HEDIS 2015 Public Comment":

   Data for this measure will be collected according to the technical specifications outlined in the "Draft Document for HEDIS 2015 Public Comment" for *Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents* (Appendix C) and will include the calculation of the following rate:

The percentage of children and adolescents 0-17 years of age who were on antipsychotic medication and who received two or more antipsychotic medication prescriptions with higher-than-recommended doses.

5. Increase the rate for Follow-up Visit for Children and Adolescents on Antipsychotics, as defined by the "Draft Document for HEDIS 2015 Public Comment":

   Data for this measure will be collected according to the technical specifications outlined in the "Draft Document for HEDIS 2015 Public Comment" for *Follow-up Visit for Children and Adolescents on Antipsychotics* (Appendix C) and will include the calculation of the following rate:

   The percentage of children and adolescents 0-17 years of age who had a new prescription for an antipsychotic medication and had one or more follow-up visits with a prescriber.

6. Increase the rate for Metabolic Screening for Children and Adolescents Newly on Antipsychotics, as defined by the "Draft Document for HEDIS 2015 Public Comment":

   Data for this measure will be collected according to the technical specifications outlined in the "Draft Document for HEDIS 2015 Public Comment" for *Metabolic Screening for Children and Adolescents Newly on Antipsychotics* (Appendix C) and will include the calculation of the following rate:

   The percentage of children and adolescents 0-17 years of age who had a new prescription for and antipsychotic medication and had baseline metabolic screening.

   *Please see Appendix C for the complete "Draft Document for HEDIS 2015 Public Comment" technical specifications for these measures.

Performance targets for all measures (Table 6) were determined based on NCQA field testing data for each measure, and are detailed in the "Gaps in Care" sections for each Measure Work-Up, also included in the "Draft Document for HEDIS 2015 Public Comment". Goals may be revised based on baseline rates so that meaningful improvement over baseline rates is targeted.

Table 6: Project Rates and Performance Targets

Performance Measure	Baseline Rate	Interim Rate	Final Rate	Performance Target
1. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	1.31%			6.0%
2. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	65.33%			48.2%
3. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	24.98%			18.5%
4. Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents	22.79%			7.9%
5. Follow-up Visit for Children and Adolescents on Antipsychotics	78.28%			72.8%
6. Metabolic Screening for Children and Adolescents Newly on Antipsychotics	0.33%			6.0%

2. Procedures

All six performance measures are specified for administrative data collection. For Indicators 1-3, sampling methodology will be utilized as defined by HEDIS® Technical Specifications (Appendix B). HEDIS® results for these indicators (1-3) will be reviewed and audited by the Plan's contracted HEDIS® auditor.

Indicators 4-6 will be measured according to specifications outlined in the "Draft Document for HEDIS 2015 Public Comment" (Appendix C). Data will be extracted via administrative claims by the Plan's Medical Informatics Department.

3. Member Confidentiality

All HIPAA Confidentiality processes and procedures are in place and will be utilized to protect member confidentiality.

4. Timeline

Baseline Measurement Period: HEDIS 2015, CY 2014

Intervention Period: CY 2015

Interim Measurement Period: HEDIS 2016, CY 2015

Intervention Period: CY 2016

Final Measurement Period: HEDIS 2017, CY 2016

Interventions / Changes for Improvement

Interventions should be targeted to the study aim and should be reasonable and practical to implement given plan population and resources.

*Through the direction and collaboration with DMS, additional interventions will be identified once baseline rates have been assessed.

1. Barrier Analyses

Category of Barrier[1]	Target Group[2]	Description of Barrier	Method of Identification[3]
Lack of Provider knowledge of and access to clinical guidelines and treatment standards for the use of antipsychotics in children and adolescents	Providers	Providers lack knowledge of current guidelines and standards of care regarding the treatment of children and adolescents with antipsychotic medications.	Health Plan Focus Group convened to review Plan data, conduct barrier analysis, and develop associated interventions. Focus Group consisted of the following Plan staff members: Medical Director, Behavioral Health Medical Director, Senior Director of Behavior Health Product Operations, Pharmacy Director, Manager of Foster Care & Adoptions, QI Manager, and QI Project Manager.
Lack of effective coordination of care between Psychiatrists, General Practitioners and/or Pediatricians, and BH Clinicians.	Providers	Lack of coordination of care exists between Providers. According to the AACAP Practice Parameters for the use of atypical antipsychotics in children and adolescents, careful diagnostic assessment with attention to comorbid medical conditions in addition to the development of a *multi-disciplinary plan*, is recommended. It is necessary that all providers	Health Plan Focus Group and Literature Review. (Please see cited studies in corresponding intervention section.)

		involved in the member's care have timely and ongoing communication regarding the member's needs and progress, in addition to an awareness of each participant's role in the member's treatment.	
Lack of access to Psychiatrists.	Members and Providers	CMHCs report that psychiatrists are currently overburdened due to a shortage of psychiatric prescribers. CMHCs report that it may take longer than intended for members to get appointments with psychiatrists due to this shortage. Consequently, members are often seeking consultation with general practitioners/pediatricians as an alternative. While general practitioners/pediatricians might be in a position to perform brief initial screenings and ongoing metabolic monitoring, referrals should be made to psychiatric providers and clinicians for a thorough evaluation and ongoing psychosocial care.	Work Group meeting, involving leadership representatives from nine Community Mental Health Centers (CMHCs) located throughout the state of KY.
Lack of member and caregiver information regarding safe use of antipsychotic medications and appropriate assessment and treatment of children's behavioral/emotional problems	Members	Members and caregivers often lack current information about psychotropic medications and appropriate assessment and treatment of children's behavioral/emotional problems. Lack of information and knowledge on the part of members and caregivers can result in a decreased ability to actively participate in decision-making regarding the child's treatment and plan of care.	Focus Group convened to review Plan data, conduct barrier analysis, and develop associated interventions. Focus Group consisted of the following Plan staff members: Medical Director, Behavioral Health Medical Director, Senior Director of Behavior Health Product Operations, Pharmacy Director, Manager of Foster Care & Adoptions, QI Manager, and QI

			Project Manager.
Lack of Plan processes to identify and address safety concerns regarding antipsychotic medication use in children and adolescents	Health Plan	The Health Plan lacks current tracking systems for identification of safety issues, including prescribing patterns, regarding antipsychotic medication use in children and adolescents.	Focus Group convened to review Plan data, conduct barrier analysis, and develop associated interventions. Focus Group consisted of the following Plan staff members: Medical Director, Behavioral Health Medical Director, Senior Director of Behavior Health Product Operations, Pharmacy Director, Manager of Foster Care & Adoptions, QI Manager, and QI Project Manager.

[1] Lack of knowledge, Lack of Access, Lack of Time, etc.
[2] Provider barrier, member barrier, health plan barrier, etc.
[3] How the barrier was identified: focus group, interview, provider or member committee, observation, etc.

2. Interventions Planned and Implemented

Complete the sections in the table below, and add more rows as needed.

Timeframe	Description of intervention	Target Group	Barriers addressed	Status (as of 9/1/15)
First Quarter 2015	The Plan will develop a Clinical Practice Guideline (CPG) for use of atypical antipsychotics in children and adolescents. The CPG will be based on the Practice Parameter for the use of Atypical Antipsychotic Medications in Children and Adolescents, developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and will be made available to providers as a resource via the Plan's Provider Website. In a 2011 9-State Study conducted by the Medicaid Medical Directors Learning	Providers	Lack of Provider knowledge of and access to clinical guidelines and treatment standards for the use of antipsychotics in children and adolescents	Modified and Implemented—In development

	Network (MMDLN), states that published guidelines on safe dosing of AP medications reported improvements in rates from a prior 16-State Study, published in 2010.[15] The AACAP Practice Parameter details 38 comprehensive recommendations regarding the use of atypical AP use in children and adolescents.			
First Quarter 2015	A comprehensive "Assessment, Screening, and Monitoring Tool", based upon recommendations included in the AACAP Practice Parameters, will be developed by The Health Plan. This tool will be made available to providers as a resource via the Plan's Provider Website. In a study published in 2011 in the Journal of the Canadian Academy of Child and Adolescent Psychiatry, community and hospital-based healthcare professionals were surveyed about the barriers associated with metabolic monitoring for youth treated with second-generation atypical antipsychotics.[16] Results from that study, based on reports from both mental health and medical providers indicated that staff were uncertain about team members' responsibility in metabolic monitoring, had limited access to appropriate equipment/tools, and low confidence in interpreting results. Based on these findings, the authors	Providers	Lack of effective coordination of care between Psychiatrists, General Practitioners and/or Pediatricians, and BH Clinicians.	Implemented

	developed a "Metabolic Monitoring Tool" to aid providers with overcoming these barriers. WellCare of Kentucky is proposing to develop a more comprehensive tool to not only include metabolic screenings, but also to assist with other important practice parameters related to overall coordination of care for the member.			
Second Quarter 2015 through Fourth Quarter 2015	Informational/educational mailings will be targeted to Providers/Prescribers. Individual providers will be identified for the mailings based on data indicating that a new prescription for an antipsychotic medication for a child, aged 0-17, was filled in the previous month. Mailings will include information on how to access the AACAP Practice Parameters via the Plan's website, in addition to the "Assessment, Screening, and Monitoring Tool". In a 2011 9-State Study conducted by the Medicaid Medical Directors Learning Network (MMDLN), states that implemented mailings and reports to providers experienced some improvement in trends relating to AP use in children.	Providers	Lack of Provider knowledge of and access to clinical guidelines and treatment standards for the use of antipsychotics in children and adolescents	Implemented—Modified to include all prescribers regardless of provider specialty type.
Second Quarter 2015	An informational/educational article for members and caregivers regarding appropriate assessment, treatment, and follow-up care for children's emotional and behavioral	Members	Lack of member and caregiver information regarding safe use of antipsychotic medications and appropriate assessment and treatment of children's behavioral	Implemented

	issues will be made available as a resource via the Plan's member newsletter. A 2010 study, conducted by Tufts Clinical And Translational Science Institute examined the status of policies and guidelines for psychotropic medication oversight across 47 states.[17] One challenge identified by states in this study was related to the involvement of parents and youth in treatment decision-making. In order to address this issue, certain states "provided ongoing information to youth and families about diagnoses, effective treatment options, and managing care throughout life", in order to aid in their ability to more actively participate in the child's treatment. WellCare of Kentucky is proposing education targeted to members and caregivers not only via the newsletter but also in form of targeted mailings, as described in the intervention below.		and emotional problems.	
Second Quarter 2015 through Fourth Quarter 2015	Informational/educational mailings will be targeted to households of members, ages 0-17, identified as "newly prescribed" an antipsychotic medication in the previous month. Members will be identified as "newly" prescribed an antipsychotic if there was at least a 120-day (4-month) negative AP medication history prior to the AP prescription fill date. The mailings will	Members	Lack of member/parent/guardian information regarding safe use of antipsychotic medications and appropriate assessment and treatment of children's behavioral and emotional problems	Implemented

	include information regarding appropriate assessment, treatment, and follow-up care for children taking antipsychotic medications.			
First Quarter 2015 through Fourth Quarter 2015	The Plan will collect/review data on a monthly basis regarding prescribing practices for AP medications in children ages 0-17. The Plan will assess frequency of prescribing by Provider Type/Specialty and will monitor outliers, such as prescriptions to children ages 5 and under, in prescribing patterns. Data will be presented quarterly to a work group, comprised of Plan staff, and interventions will be determined as needed. When outliers are identified, information will be forwarded to the Plan's Quality of Care (QOC) Department for further review by the QOC Nurse and the Behavioral Health Medical Director, as necessary. Multiple studies, including the MMDLN 16-state (2010) and 9-state (2011) studies, as wells as the 47-state Tufts Study (2010), examined the use of "red flag" monitoring systems, implemented by states, to assess "outliers" related to AP Prescribing patterns and use among children and adolescents. WellCare of Kentucky proposes to implement a system of reviewing and responding to such outliers upon further, careful review of Plan	Health Plan	Lack of Plan processes to identify and address safety concerns regarding antipsychotic medication use in children and adolescents	Implemented

	data, including data related to performance measures for this project.			
First Quarter 2015--Review	The Plan is currently continuing to assess this identified barrier, related to current shortages of psychiatrists in Kentucky. The Plan will evaluate current resources in order to identify potential interventions, such as the ability to provide psychiatric consultations or second opinions to general practitioners/pediatricians when needed regarding screening, diagnosis, referral, and treatment options (including medication management). According to the 16-state MMDLN study (2010), states such as Massachusetts and Washington, implemented programs to provide telephonic consultations and support to pediatricians by specialists in child psychiatry. In the MMDLN subsequent 9-state follow-up study (2011), it is reported that states who implemented these programs saw as much as a 60% decrease in rates relating to AP use in children. Additionally, according to the Tufts (2010) multi-state study, some other states developed tele-psychiatry programs to address shortages of specialists in rural areas. WellCare of Kentucky is proposing to evaluate Plan resources and feasibility for implementation of	Members and Providers	Lack of access to Psychiatrists.	Reviewed and not approved for implementation at this time.

	similar programs.			
First Quarter 2015--Review	The Plan is currently evaluating additional potential interventions aimed at improving Provider education, such as the ability/resources to coordinate an educational conference/summit regarding best practices related to screening, assessment, diagnosis, and treatment of behavioral health disorders in children. A series of eight webinars, made possible by the Center for Health Care Strategies (June 2013 to October 2014), were presented on the topics of Psychotropic Medications and Foster Care.[18] Although the webinars had a strong tailoring toward the foster-care sub-populations with regard to overall psychotropic medication use, certain practices and recommendations are applicable to any Medicaid-eligible population of youth being treated with psychotropic medications. Webinars included Red Flag and Response Systems; Telephonic Consultation Models; Improving Psychotropic Medication Oversight; Facilitating Cross-System Data Sharing; Trauma-informed Screening, Assessment, and Treatment for Children and Youth in Child Welfare Systems; Use & Financing of Non-Pharmacologic Evidenced-based Practices as Alternatives to	Providers	Lack of Provider knowledge of and access to clinical guidelines and treatment standards for the use of antipsychotics in children and adolescents	Reviewed and not approved for implementation at this time

	Psychotropic Medications; Quality of Care Measures; and Models of Agency Consent. While the details and recommendations outlined in each webinar are too numerous to account here, WellCare of Kentucky would like to examine the feasibility of implementing a similar compendium of educational resources for Providers and other Health Care Professionals in the state of Kentucky.			

3. Process Measures

Intervention Name/Description	Related Process Measure
Informational/educational mailings will be targeted to Prescribers/Providers on a monthly basis. Individual providers will be identified for the mailings based on data indicating that a new prescription for an antipsychotic medication for a child, aged 0-17, was filled in the previous month. Mailings will include information on how to access the AACAP Practice Parameters via the Plan's website, in addition to the "Assessment, Screening, and Monitoring Tool".	The Plan will track the total number of Providers identified for mailings each month and the total number of Providers outreached via mailing each month, as well as total # of returned mailings due to incorrect provider addresses each month.
Informational/educational mailings will be targeted to households of members, ages 0-17, identified as "newly prescribed" an antipsychotic medication in the previous month. Members will be identified as "newly" prescribed an antipsychotic if there was at least a 120-day (4-month) negative AP medication history prior to the AP prescription fill date. The mailings will include information regarding appropriate assessment, treatment, and follow-up care for children taking antipsychotic medications.	The Plan will track the total number of member households identified for mailings each month and the total number of member households outreached via mailing each month, as well as total # of returned mailings due to incorrect member addresses each month.
The Plan will collect/review data on a monthly basis regarding prescribing practices for AP medications in children ages 0-17. The Plan will assess frequency of prescribing by Provider Type and will monitor outliers, such as prescriptions to children under age 5, in prescribing patterns. Data will be presented quarterly to a work group, comprised of Plan staff, and interventions will be determined as	The Plan will collect data on the following: Total number of AP Prescriptions filled each month, including Member name, DOB, demographics (address, region, LOB, race, sex), AP Prescription Name, AP Class, AP Dose, AP fill date, Prescriber name, Prescriber Type and Specialty, Prescriber Address/Contact Information.

needed. When outliers are identified, information will be forwarded to the Plan's Quality of Care (QOC) Department for further review by the QOC Nurse and the Behavioral Health Medical Director, as necessary.	Outliers may be determined based on the following, and may be modified as needed pending further evaluation of Plan data: AP Prescriptions for Members ages 0-5 and AP Prescriptions by non-psychiatric provider types. The Plan will track the following regarding QOC referrals: Total number of outliers Identified, reasons identified as outliers (see above), total number of cases referred to QOC for review, and QOC review dispositions.

4. PDSA (Plan-Do-Study-Act) Project Phases

[If a PDSA method was performed, provide information regarding the interim phases of the project; i.e., (1) the objective and plan to test for change, (2) the action carried out (including documenting problems or unexpected observations), (3) the results or knowledge gained, and (4) the actions that were taken as a result of the cycle (e.g., modifications made based on what was learned). Discuss any changes or tailoring of interventions and rationale for doing so. Process measures that led to modifications in your interventions should be presented here.]

1. **Objective/Plan**

2. **Action**

3. **Results**

4. **Modified Actions and Rationale**

Results

The results section should quantify project findings related to each study question and project indicators. **Do not** interpret the results in this section.

Analysis of WellCare of Kentucky data for Calendar Year (CY) 2014 indicates that there were 219,691 Medicaid members, ages zero to seventeen. Of those members, 15.74 percent (n=34,571of 219,691) had at least one behavioral health diagnosis, and 1.60 percent (n=3,522 of 219,691) had at least one prescription for an antipsychotic medication. Data within each of these categories is further stratified by age, sex, race, Medicaid Line of Business, and Region (Please see Table 1).

Table 1: 2014 Demographic Stratifications within Categories: Overall Medicaid Members Ages 0-17, Members with ≥ 1 Behavioral Health (BH) Diagnosis (Dx), Members with ≥ 1 Antipsychotic (AP) Prescription (Rx)

	Medicaid Members 0-17	%	Members with ≥ 1 BH Dx	%	Members with ≥ 1 AP Rx	%
	N=219691		N=34571		N=3522	
AGE						
0 TO 5	78221	35.61%	3237	9.36%	38	1.08%
6 TO 11	76215	34.69%	15391	44.52%	1199	34.04%
12 TO 17	65255	29.70%	15943	46.12%	2285	64.88%
SEX						
Male	112784	51.34%	21047	60.88%	2356	66.89%
Female	106905	48.66%	13524	39.12%	1166	33.11%
Unknown	2	0.00%				
Race						
White	136305	62.04%	22313	64.54%	2054	58.32%
Black	13399	6.10%	1946	5.63%	222	6.30%
Other	56988	25.94%	5701	16.49%	230	6.53%
Unknown	11522	5.24%	4506	13.03%	1008	28.62%
Asian	874	0.40%	56	0.16%	6	0.17%
American Indian	440	0.20%	38	0.11%	2	0.06%
Hawaiian	163	0.07%	11	0.03%	0	0.00%
Line of Business						
KMD	202409	92.13%	25882	74.87%	1495	42.45%
KAB	11218	5.11%	5909	17.09%	1305	37.05%
KHK	6064	2.76%	2780	8.04%	722	20.50%
Region						
Region 1	14068	6.40%	2417	6.99%	300	8.52%
Region 2	22704	10.33%	3999	11.57%	559	15.87%

Region 3	15305	6.97%	1701	4.92%	140	3.98%
Region 4	32760	14.91%	4876	14.10%	472	13.40%
Region 5	46919	21.36%	6932	20.05%	711	20.19%
Region 6	18929	8.62%	3241	9.37%	408	11.58%
Region 7	19875	9.05%	3415	9.88%	365	10.36%
Region 8	49131	22.36%	7990	23.11%	567	16.10%

Prevalence rates for behavioral health (BH) diagnoses in proportion to the total overall Medicaid population, ages 0-17, are presented in Table 2. (Please see Appendix A for a complete listing of counties in each region and a corresponding map of Kentucky regions).

Table 2: 2014 Behavioral Health Diagnoses Prevalence Rates in Proportion to the Overall Population

	Medicaid Members 0-17	Members with ≥ 1 BH Dx	%
	N=219691	N=34571	15.74%
AGE			
0 TO 5	78221	3237	4.14%
6 TO 11	76215	15391	20.19%
12 TO 17	65255	15943	24.43%
SEX			
Male	112784	21047	18.66%
Female	106905	13524	12.65%
Unknown	2		0.00%
Race			
White	136305	22313	16.37%
Black	13399	1946	14.52%
Other	56988	5701	10.00%
Unknown	11522	4506	39.11%
Asian	874	56	6.41%
American Indian	440	38	8.64%
Hawaiian	163	11	6.75%
Line of Business			
KMD	202409	25882	12.79%
KAB	11218	5909	52.67%
KHK	6064	2780	45.84%
Region			
Region 1	14068	2417	17.18%
Region 2	22704	3999	17.61%
Region 3	15305	1701	11.11%
Region 4	32760	4876	14.88%
Region 5	46919	6932	14.77%
Region 6	18929	3241	17.12%

Region 7	19875	3415	17.18%
Region 8	49131	7990	16.26%

Stratified rates (CY 2014) of Antipsychotic Use in proportion to the total overall Medicaid population, ages 0-17, are presented in Table 3. (Please see Appendix A for a complete listing of counties in each region and a corresponding map of Kentucky regions).

Table 3: 2014 Stratified Antipsychotic Use Rates in Proportion to the Overall Population

	Medicaid Members 0-17	Members with ≥ 1 AP Rx	%
	N=219691	N=3522	1.60%
AGE			
0 TO 5	78221	38	0.05%
6 TO 11	76215	1199	1.57%
12 TO 17	65255	2285	3.50%
SEX			
Male	112784	2356	2.09%
Female	106905	1166	1.09%
Unknown	2		0.00%
Race			
White	136305	2054	1.51%
Black	13399	222	1.66%
Other	56988	230	0.40%
Unknown	11522	1008	8.75%
Asian	874	6	0.69%
American Indian	440	2	0.45%
Hawaiian	163	0	0.00%
Line of Business			
KMD	202409	1495	0.74%
KAB	11218	1305	11.63%
KHK	6064	722	11.91%
Region			
Region 1	14068	300	2.13%
Region 2	22704	559	2.46%
Region 3	15305	140	0.91%
Region 4	32760	472	1.44%
Region 5	46919	711	1.52%
Region 6	18929	408	2.16%
Region 7	19875	365	1.84%
Region 8	49131	567	1.15%

WellCare of Kentucky further assessed data for 2014 for the prevalence of antipsychotic prescriptions amongst members who had a least one behavioral health diagnosis in the measurement year (Table 4). Additionally, data was assessed for the proportion of members who were prescribed an antipsychotic medication but did not have a behavioral health diagnosis in the same year.

Table 4: 2014 Prevalence of Behavioral Health Diagnosis Among Members with an Antipsychotic Prescription

	Members 0-17 with BH Dx	%
Members with AP Rx	3444	9.96%
Members without AP Rx	31127	90.04%
Total	34571	100%
	Members 0-17 with AP Rx	%
Members with BH Dx	3444	97.79%
Members without BH Dx	78	2.21%
Total	3522	100%

WellCare of Kentucky conducted additional analysis of CY 2014 pharmacy data regarding prescriber practices. This data was based on paid claims for filled antipsychotic medication prescriptions in the CY for members, ages 0-17. Data was filtered, based on max fill date for prescriptions by members, associated with unique prescribers. Therefore, if the prescriber varied from month to month for a single medication per member, this was reflected in the data. Max fill date is defined as the most recent fill date for a unique Antipsychotic Medication in the CY. Data (Table 5) is stratified by Provider Type and Provider Specialty. Provider Types and Specialties were determined via the KY State File Roster of Providers.

Table 5: 2014 Prescriber Types and Specialties for Antipsychotic Medications for Members ages 0-17.

	Frequency of Prescriber Type/Specialty	%
Physician	**6536**	**77.47%**
Psychiatrist	3041	36.04%
General Practitioner	2852	33.80%
General Pediatrician	399	4.73%
Physical Medicine and Rehabilitation Practitioner	94	1.11%
Family Practitioner	79	0.94%
Internist	33	0.39%
Neurologist	24	0.28%
Osteopathy	5	0.06%
Cardiologist	2	0.02%
Anesthesiologist	2	0.02%
Obstetrician/Gynecologist	2	0.02%
Emergency Medicine Practitioner	2	0.02%
Ophthalmologist	1	0.01%
Advanced Registered Nurse Practitioner	**1766**	**20.93%**
Nurse Practitioner (Other)	1558	18.47%
Family Nurse Practitioner	146	1.73%

Psychiatric Nurse Practitioner	45	0.53%
Pediatric Nurse Practitioner	17	0.20%
Physician Assistant	**135**	**1.60%**
Grand Total	**8437**	**100.00%**

Administrative claims data, collected according to HEDIS 2015 Technical Specifications, yielded the following baseline rates for performance measures. Rates are stratified by age, sex, race, Line of Business (LOB), Region, and Total Rate.

Performance Measure 1: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
1-5	26	1	3.85%	
6-11	864	7	0.81%	
12-17	1472	23	1.56%	
Sex				
Male	1630	19	1.17%	
Female	732	12	1.64%	
Race				
White	1438	14	0.97%	
Unknown Race	683	16	2.34%	
Black or African American	133	1	0.75%	
Other	101	0	0.00%	
Asian	5	0	0.00%	
American Indian and Alaska Native	1	0	0.00%	
Native Hawaiian and Other Pacific Islander	1	0	0.00%	
LOB				
KMD	920	9	0.98%	
KAB	896	14	1.56%	
KHK	546	8	1.47%	
Region				
Region 1	219	2	0.91%	
Region 2	363	7	1.93%	
Region 3	92	1	1.09%	
Region 4	325	2	0.62%	
Region 5	448	0	0.00%	
Region 6	267	4	1.50%	
Region 7	264	8	3.03%	
Region 8	384	7	1.82%	
Total Rate	**2362**	**31**	**1.31%**	**6.0%**

Performance Measure 2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
1-5	23	18	78.26%	
6-11	332	208	62.65%	
12-17	617	409	66.29%	
Sex				
Male	583	363	62.26%	
Female	389	272	69.92%	
Race				
White	637	419	65.78%	
Unknown Race	186	118	63.44%	
Black or African American	73	50	68.49%	
Other	70	45	64.29%	
Asian	3	1	33.33%	
American Indian and Alaska Native	2	2	100.00%	
Native Hawaiian and Other Pacific Islander	1	0	0.00%	
LOB				
KMD	511	353	69.08%	
KAB	251	170	67.73%	
KHK	210	112	53.33%	
Region				
Region 1	73	33	45.21%	
Region 2	168	123	73.21%	
Region 3	49	37	75.51%	
Region 4	120	88	73.33%	
Region 5	210	119	56.67%	
Region 6	140	91	65.00%	
Region 7	62	34	54.84%	
Region 8	150	110	73.33%	
Total Rate	**972**	**635**	**65.33%**	**48.2%**

Performance Measure 3: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
1-5	41	8	19.51%	
6-11	1070	238	22.24%	
12-17	1916	510	26.62%	
Sex				
Male	2032	492	24.21%	

Female	995	264	26.53%	
Race				
White	1838	451	24.54%	
Unknown Race	852	218	25.59%	
Black or African American	198	54	27.27%	
Other	130	29	22.31%	
Asian	6	2	33.33%	
American Indian and Alaska Native	2	1	50.00%	
Native Hawaiian and Other Pacific Islander	1	1	100.00%	
LOB				
KMD	1228	283	23.05%	
KAB	1118	288	25.76%	
KHK	681	185	27.17%	
Region				
Region 1	267	94	35.21%	
Region 2	484	44	9.09%	
Region 3	132	41	31.06%	
Region 4	394	107	27.16%	
Region 5	595	174	29.24%	
Region 6	351	66	18.80%	
Region 7	314	106	33.76%	
Region 8	490	124	25.31%	
Total Rate	**3027**	**756**	**24.98%**	**18.5%**

Administrative claims data, collected according to "Draft Document for HEDIS 2015 Public Comment", yielded the following baseline rates for performance measures. Rates are stratified by age, sex, race, Line of Business (LOB), Region, and Total Rate.

Performance Measure 4: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents

Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
0-5	40	6	15.00%	
6-11	1108	291	26.26%	
12-17	1958	411	20.99%	
Sex				
Male	2113	501	23.71%	
Female	993	207	20.85%	
Race				
White	1766	362	20.50%	
Unknown	895	224	25.03%	
Other	247	65	26.32%	
Black	188	54	28.72%	
Asian	6	2	33.33%	
American Indian	3	1	33.33%	

Hawaiian	1	0	0.00%	
LOB				
KMD	1272	278	21.86%	
KAB	1154	289	25.04%	
KHK	680	141	20.74%	
Region				
Region 1	279	65	23.30%	
Region 2	484	130	26.86%	
Region 3	141	38	26.95%	
Region 4	417	81	19.42%	
Region 5	628	139	22.13%	
Region 6	341	96	28.15%	
Region 7	334	64	19.16%	
Region 8	482	95	19.71%	
Total Rate	**3106**	**708**	**22.79%**	**7.9%**

Performance Measure 5: Follow-up Visit for Children and Adolescents on Antipsychotics

Follow-up Visit for Children and Adolescents on Antipsychotics Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
0-5	8	7	87.50%	
6-11	488	370	75.82%	
12-17	912	683	74.89%	
Sex				
Male	971	716	73.74%	
Female	437	344	78.72%	
Race				
White	844	636	75.36%	
Unknown Race	427	325	76.11%	
Black or African American	80	57	71.25%	
Other	54	40	74.07%	
Asian	2	2	100.00%	
American Indian	1	0	0.00%	
LOB				
KMD	560	430	76.79%	
KAB	535	409	76.45%	
KHK	313	221	70.61%	
Region				
Region 1	120	83	69.17%	
Region 2	254	179	70.47%	
Region 3	36	22	61.11%	
Region 4	202	162	80.20%	
Region 5	239	188	78.66%	
Region 6	131	90	68.70%	

Region 7	173	129	74.57%	
Region 8	253	207	81.82%	
Total Rate	**1408**	**1060**	**75.28%**	**72.8%**

Performance Measure 6: Metabolic Screening for Children and Adolescents Newly on Antipsychotics

Metabolic Screening for Children and Adolescents Newly on Antipsychotics Measurement Year 2014				
Age	**Denominator**	**Numerator**	**Rate**	**Performance Target**
0-5	18	0	0.00%	
6-11	980	1	0.10%	
12-17	1751	8	0.46%	
Sex				
Male	1895	5	0.26%	
Female	854	4	0.47%	
Race				
White	1610	6	0.37%	
Unknown	793	3	0.38%	
Other	178	0	0.00%	
Black	161	0	0.00%	
American Indian	3	0	0.00%	
Asian	3	0	0.00%	
Hawaiian	1	0	0.00%	
LOB				
KMD	1274	4	0.31%	
KAB	1011	3	0.30%	
KHK	464	2	0.43%	
Region				
Region 1	260	0	0.00%	
Region 2	525	0	0.00%	
Region 3	58	1	1.72%	
Region 4	365	3	0.82%	
Region 5	471	3	0.64%	
Region 6	278	0	0.00%	
Region 7	308	2	0.65%	
Region 8	484	0	0.00%	
Total Rate	**2749**	**9**	**0.33%**	**6.0%**

Discussion

The discussion section is for explanation and interpretation of the results.

1. Discussion of Results

Analysis of WellCare of Kentucky data for CY 2014 indicates that there were 219,691 Medicaid members, ages zero to seventeen. Of those members, 15.74 percent had at least one behavioral health diagnosis, and 1.60 percent filled at least one prescription for an antipsychotic medication. For all pediatric members with a behavioral health diagnosis (n=34,571), 9.96 percent were treated with at least one antipsychotic medication in the same year. Data further indicate that of the 3,522 pediatric members with at least one antipsychotic prescription, 97.79% also had a corresponding behavioral health diagnosis; 2.21 percent did not.

According to this data, rates of BH diagnosis increased with age and male Medicaid recipients (ages 0-17) were more likely than female recipients to receive at least one behavioral health diagnosis in 2014 (18.66 percent vs. 12.65 percent). Prevalence of BH diagnosis varied between races, with the largest proportion identified as "Unknown". Members enrolled in the KAB (Kentucky Aged, Blind, and Disabled) Medicaid Line of Business (LOB) had the highest rate of BH diagnosis at 52.67 percent, followed by KHK foster care members at 45.84 percent, and lastly by traditional Medicaid recipients (KMD) with a 12.79 percent rate of diagnosis. Regional rates varied among members, with members in Region Two representing the greatest proportion of members with a BH diagnosis, relative to the general overall population, at 17.61 percent.

Further analysis of CY 2014 data indicate that antipsychotic medication use rates increased with age and male Medicaid recipients (ages 0-17) were nearly twice as likely as female recipients to be prescribed an antipsychotic medication (2.09 percent vs. 1.09 percent). Antipsychotic use rates varied between races, with the largest proportion identified as "Unknown". Members enrolled in the KHK (foster care) Medicaid Line of Business had the highest rate of use at 11.91 percent, followed closely by KAB (Kentucky Aged, Blind, or Disabled) members at 11.63 percent, and lastly by traditional Medicaid recipients (KMD) with a 0.74 percent rate of use. Regional rates varied among members, with members in Region Two representing the greatest proportion of members with an antipsychotic prescription, relative to the general overall population, at 2.46 percent.

WellCare of Kentucky conducted additional analysis of CY 2014 pharmacy data to evaluate trends in prescriber practices for pediatric antipsychotic prescriptions. According to this data, 77.47 percent of prescriptions were written by a physician, 20.93 percent were written by an advanced registered nurse practitioner, and 1.60 percent by a physician assistant. Of the 8,437 antipsychotic prescriptions included in this data, 36.04% were written by a psychiatrist and 0.53 percent by a psychiatric nurse practitioner. All other prescriptions for a pediatric antipsychotic medication were written by a non-psychiatric provider specialty type at 63.42%.

Baseline data were collected and evaluated for six performance measures for this project. HEDIS 2015 data indicate that 1.31 percent of members, ages 1-17, received two or more concurrent antipsychotic medications. This rate exceeded the initial goal rate of 6.0 percent, since a lower rate indicates better performance for this measure.

HEDIS 2015 data indicate that 65.33 percent of pediatric members, ages 1-17, who had a new prescription for an antipsychotic medication also had documentation of psychosocial care as first-line treatment. This rate also exceeded the initial performance target of 48.2 percent.

HEDIS 2015 data further indicate that 24.98 percent of members, ages 1-17, who had two or more antipsychotic prescriptions, also received metabolic testing during the measurement year. This rate exceeded the initial goal rate of 18.5 percent.

Administrative claims data for CY 2014, collected according to the specifications outlined in the "Draft Document for HEDIS 2015 Public Comment, were evaluated for the final three performance measures for this project. This data indicated a baseline rate of 22.79 percent for pediatric members, ages 0-17, who were on antipsychotic medication and who received two or more antipsychotic prescriptions with higher-than-recommended doses. This rate did not meet the initial goal rate of 7.9 percent, since a lower rate indicated better performance for this measure.

Baseline data for CY 2014 also indicate that 75.28 percent of members, ages 0-17, who had a new prescription for an antipsychotic medication, also had one or more follow up visits with a prescriber within thirty days following the index prescription start date. This rate exceeded the initial goal rate of 72.8 percent.

Lastly, baseline data for CY 2014 indicate that 0.33 percent of members, ages 0-17, who had a new prescription for an antipsychotic medication, also had a baseline metabolic screening within ninety days prior to the prescription start date to fifteen days after the prescription start date. This rate did not meet the initial goal rate of 6.0%.

The Plan has begun implementation of several interventions associated with this project, aimed at improving the care of pediatric members being treated with antipsychotic medications. The Plan began development of a Clinical Practice Guideline (CPG) for use of atypical antipsychotics in children and adolescents. The CPG is based on the Practice Parameter for the use of Atypical Antipsychotic Medications in Children and Adolescents, developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and will be made available to providers as a resource. The CPG is currently in draft form and is pending approval by the Plan's Medical Policy Committee (MPC), the Plan's Pharmacy Committee, and the Utilization Management Committee (UMAC).

The Plan also developed a comprehensive "Assessment, Screening, and Monitoring Tool", based upon recommendations included in the AACAP Practice Parameter. This tool has been made available to providers as a resource via the Plan's provider website.

The Plan initiated informational/educational mailings in the second quarter 2015 to households of members, ages 0-17, identified as newly prescribed an antipsychotic medication. The mailings include information regarding appropriate assessment, treatment, and follow-up care for children taking an antipsychotic (please see Appendix D for the letter template). The Plan will report the number of member mailings generated in CY 2015 in the interim report for this project.

The Plan initiated informational/educational mailing to providers in the third quarter 2015. These mailings are targeted to providers based on data indicating that a new prescription for an antipsychotic medication was initiated in the previous month for a pediatric member (please see Appendix E for the letter template). The Plan will report the number of provider mailings generated in CY 2015 in the interim report for this project.

The Plan began collecting and reviewing monthly data in the first quarter 2015 regarding prescribing practices for pediatric antipsychotic prescriptions. The Plan assesses the frequency of prescriptions by provider types and monitors outliers, such as prescriptions to children, ages five and under. As outliers are identified, information is then forwarded to the Plan's Quality of Care (QOC) department for further review by the QOC nurse and the Plan's Behavioral Medical Director. The Plan will report these metrics for CY 2015 in the interim report for this project.

2. Limitations

No limitations have been identified at this time.

3. Member Participation

All pediatric members, ages zero to seventeen, who were treated with an antipsychotic medication during the measurement year, were eligible for interventions associated with this project.

4. Financial Impact

Financial impact is undetermined at this time.

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

1. Lessons Learned

[Describe what was learned from the project, topics/areas for further study, and whether findings can be extrapolated to other members or systems.]

2. Dissemination of Findings

[Address how the results and conclusions have been/will be made available to members, providers or other interested parties and the methods used to make the findings available, such as via the member/provider newsletters, meetings/presentations, and/or website posting. Identify future goals for disseminating the project's key findings and lessons learned.]

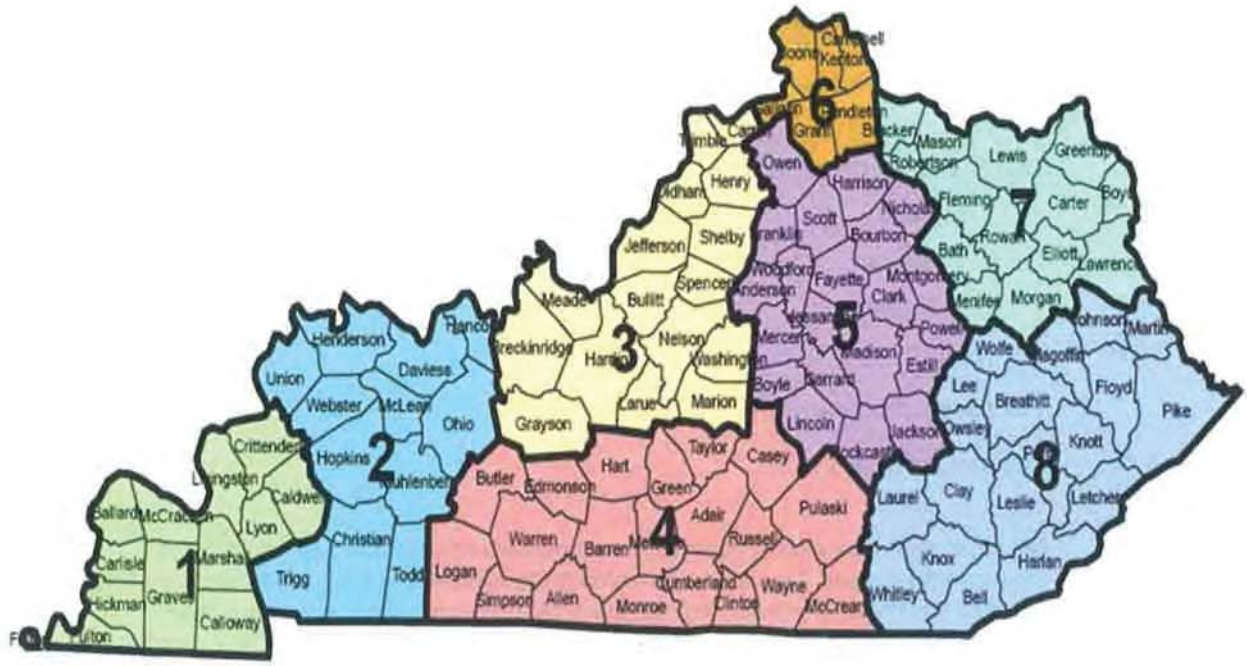
3. System-level Changes Made and/or Planned

[Describe how the findings will be used, actions that will be taken to sustain improvement, and plans to spread successful interventions to other organizational processes, as applicable.]

Appendix A: Kentucky Counties by Region

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Ballard	Christian	Breckinridge	Adair	Anderson	Boone	Bath	Bell
Caldwell	Daviess	Bullitt	Allen	Bourbon	Campbell	Boyd	Breathitt
Calloway	Hancock	Carroll	Barren	Boyle	Gallatin	Bracken	Clay
Carlisle	Henderson	Grayson	Butler	Clark	Grant	Carter	Floyd
Crittenden	Hopkins	Hardin	Casey	Estill	Kenton	Elliott	Harlan
Fulton	McLean	Henry	Clinton	Fayette	Pendleton	Fleming	Johnson
Graves	Muhlenberg	Jefferson	Cumberland	Franklin		Greenup	Knott
Hickman	Ohio	Larue	Edmonson	Garrard		Lawrence	Knox
Livingston	Todd	Marion	Green	Harrison		Lewis	Laurel
Lyon	Trigg	Meade	Hart	Jackson		Mason	Lee
McCracken	Union	Nelson	Logan	Jessamine		Menifee	Leslie
Marshall	Webster	Oldham	McCreary	Lincoln		Morgan	Letcher
		Shelby	Metcalfe	Madison		Robertson	Magoffin
		Spencer	Monroe	Mercer		Rowan	Martin
		Trimble	Pulaski	Montgomery			Owsley
		Washington	Russell	Nicholas			Perry
			Simpson	Owen			Pike
			Taylor	Powell			Whitley
			Warren	Rockcastle			Wolfe
			Wayne	Scott			
				Woodford			

Kentucky Map of Regions



Appendix B: HEDIS® 2015 Technical Specifications for Safe and Judicious Antipsychotic Use in Children and Adolescents

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

SUMMARY OF CHANGES TO HEDIS 2015

First-year measure.

Description

The percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications.

Note: *A lower rate indicates better performance.*

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report three age stratifications and a total rate: 1–5 years. 6–11 years. 12–17 years. Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	Members with 90 days of continuous antipsychotic medication treatment during the measurement year. Use the steps below to determine the eligible population.
Step 1	Identify members in the specified age range who were dispensed an antipsychotic medication (Table APC-A) during the measurement year.
Step 2	Calculate continuous enrollment. The member must be continuously enrolled during the measurement year.
Step 3	For each member, identify all antipsychotic medication dispensing events (prescriptions) during the measurement year.

Step 4 Identify start and end dates for drug events. Drug events are defined separately by drug using the Drug ID field in the NDC list.

For each drug ID, sort dispensing events chronologically by dispense date. If there is more than one prescription for the same medication dispensed on the same day, use only the prescription with the longest days supply in the calculation.

Starting with the first prescription in the measurement year determine if there is a second dispense date with the same Drug ID.

If there is no second dispensing event with the same Drug ID, the start date is the first prescription's dispense date and the end date is the start date plus the days supply minus one. For example, a January 1 prescription with a 30 days supply has an end date of January 30.

If there is a second dispensing event with the same Drug ID, determine if there are gap days (a 32-day gap is allowed). Calculate the number of days between (but not including) the first prescription's dispense date and the second prescription's dispense date. If the number of days is less than or equal to the first prescription's days supply plus 32 days, the gap is less than or equal to 32 days and is allowed. The start date is the first prescription's dispense date and the end date is the second prescription's dispense date plus days supply minus one. Continue assessing all subsequent dispensing events with allowable gaps for the same Drug ID and adjust end dates as needed.

For example, a member has two dispensing events with the same Drug ID. The first is on July 1, with a 30 days supply. The second is on September 1, with a 30 days supply. The number of days between (but not including) the dispense dates is 61 (July 2–August 31).The gap is allowed because 61 is less than the first prescription's days supply plus 32 days (30 + 32 = 62). The start date is July 1 and the end date is September 30.

If there is a second dispensing event with the same Drug ID and there is a gap that exceeds the allowable gap, assign an end date for this drug event and follow the beginning of step 4 for the remaining dispensing events. A member can have multiple start and end dates per Drug ID during the measurement year.

Continue assessing each dispensed prescription for each Drug ID until all dispensing events are exhausted. If a dispensing event goes beyond December 31 of the measurement year, assign the end date as December 31.

Step 5 For each member, identify those with ≥90 consecutive treatment days.

For each member, using the start and end dates from all drug events identified in step 4 (which may include events for the same or different medications and may include events with allowable gaps), determine all calendar days covered by at least one antipsychotic medication. If there were ≥90 consecutive calendar days, include the member in the measure.

Table APC-A. Antipsychotic Medications

Description	Prescription		
First Generation Antipsychotic Medications	Chlorpromazine HCL Fluphenazine HCL Fluphenazine decanoate Fluphenazine enanthate Haloperidol Haloperidol decanoate	Haloperidol lactate Loxapine HCL Loxapine succinate Molindone HCL Perphenazine Pimozide	Promazine HCL Thioridazine HCL Thiothixene Thiothixene HCL Trifluoperazine HCL • Triflupromazine HCL
Second Generation Antipsychotic Medications	Aripiprazole Clozapine Iloperidone Olanzapine	Olanzapine pamoate Paliperidone Paliperidone palmitate Quetiapine fumarate	Risperidone Risperidone microspheres Ziprasidone HCL Ziprasidone mesylate

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Administrative Specification

Denominator The eligible population.

Numerator Members on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Use the steps below to determine the numerator.

Step 1 For each member, by Drug ID, identify all drug events, start dates and end dates (identified in step 4 of the event/diagnosis criteria used to identify the eligible population [denominator]).

Step 2 Identify concurrent antipsychotic medication treatment events as follows.

For each member, identify the first day during the measurement year where the member was being treated with two or more different antipsychotic medications (use the Drug ID to identify different drugs); this is the concurrent antipsychotic medication treatment event start date.

Beginning with (and including) the start date, identify the number of consecutive days where the member remains on two or more different antipsychotic medications. If the number of days ≥90 days, the member is numerator compliant.

If the number of consecutive days on multiple antipsychotic medications is <90 days, identify the end date and identify the next day during the measurement year where the member was being treated with two or more different antipsychotic medications. If the number of days between the end date and the next start date is ≤15 days, include the days in the concurrent antipsychotic medication treatment event (*concurrent antipsychotic medication treatment events* allow for a 15-day gap).

If the number of days between the end date and the next start date exceeds 15 days, end the event; using the new start date, continue to assess for concurrent antipsychotic medication treatment events.

Continue this process until the number of concurrent antipsychotic medication treatment days is ≥90 consecutive days (i.e., the member is numerator compliant) or until the measurement year is exhausted (i.e., no concurrent antipsychotic medication treatment events were identified during the measurement year).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APC-1/2: Data Elements for Use of Multiple Concurrent Antipsychotics in Children and Adolescents

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	For each age stratification and total
Reported rate	For each age stratification and total
Lower 95% confidence interval	For each age stratification and total
Upper 95% confidence interval	For each age stratification and total

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

SUMMARY OF CHANGES TO HEDIS 2015

First-year measure.

Description

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.

Definitions

Intake Period	January 1 through December 1 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report three age stratifications and a total rate: 1–5 years. 6–11 years. 12–17 years. Total. The total is the sum of the age stratifications.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	None.
Anchor date	IPSD.
Benefit	Medical, mental health, pharmacy.
Event	Follow the steps below to identify the eligible population.
Step 1	Identify all members in the specified age range who were dispensed an antipsychotic medication (Table APP–A) during the Intake Period.
Step 2	Test for Negative Medication History. For each member identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4: Required exclusions Exclude members for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria:

At least one acute inpatient encounter with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria:

BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set.

BH Stand Alone Acute Inpatient Value Set ***with*** Bipolar Disorder Value Set.

BH Stand Alone Acute Inpatient Value Set ***with*** Other Psychotic Disorders Value Set.

BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Schizophrenia Value Set.

BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Bipolar Disorder Value Set.

BH Acute Inpatient Value Set ***with*** BH Acute Inpatient POS Value Set ***and*** Other Psychotic Disorders Value Set.

At least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria:

BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Schizophrenia Value Set.

BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Schizophrenia Value Set.

BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Bipolar Disorder Value Set.

BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Bipolar Disorder Value Set.

BH Stand Alone Outpatient/PH/IOP Value Set ***with*** Other Psychotic Disorders Value Set.

BH Outpatient/PH/IOP Value Set ***with*** BH Outpatient/PH/IOP POS Value Set ***and*** Other Psychotic Disorders Value Set.

Table APP-A. Antipsychotic Medications

Description	Prescription		
First-generation antipsychotic medications	Chlorpromazine HCL	Molindone HCL	Promazine HCL
	Fluphenazine HCL	Perphenazine	Thioridazine HCL
	Fluphenazine decanoate	Pimozide	Thiothixene
	Fluphenazine enanthate	Haloperidol lactate	Thiothixene HCL
	Haloperidol	Loxapine HCL	Trifluoperazine HCL
	Haloperidol decanoate	Loxapine succinate	Trifluprom azine HCL
Second-generation antipsychotic medications	Aripiprazole	Olanzapine pamoate	Risperidone
	Clozapine	Paliperidone	Risperidone microspheres
	Iloperidone	Paliperidone palmitate	Ziprasidone HCL
	Olanzapine	Quetiapine fumarate	Ziprasidone mesylate
Combinations	Olanzapine-fluoxetine HCL (Symbyax)	Perphenazine-amitriptyline HCL (Etrafon, Triavil [various])	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Administrative Specification

Denominator The eligible population.

Numerator Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APP-1/2: Data Elements Access to Psychosocial Care for Children and Adolescents on Antipsychotics

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	For each age stratification and total
Number of required exclusions	For each age stratification and total
Numerator events by administrative data	For each age stratification and total
Reported Rate	For each age stratification and total
Lower 95% confidence interval	For each age stratification and total
Upper 95% confidence interval	For each age stratification and total

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

SUMMARY OF CHANGES TO HEDIS 2015

First-year measure.

Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report three age stratifications and a total rate: 1–5 years. 6–11 years. 12–17 years. Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (Table APM-A) of the same or different medications, on different dates of service during the measurement year.

Table APM-A. Antipsychotic Medications

Description	Prescription		
First-generation antipsychotic medications	Chlorpromazine HCL Fluphenazine HCL Fluphenazine decanoate Fluphenazine enanthate Haloperidol Haloperidol decanoate	Haloperidol lactate Loxapine HCL Loxapine succinate Molindone HCL Perphenazine Pimozide	Promazine HCL Thioridazine HCL Thiothixene Thiothixene HCL Trifluoperazine HCL Triflupromazine HCL
Second generation antipsychotic medications	Aripiprazole Clozapine Iloperidone Olanzapine	Olanzapine pamoate Paliperidone Paliperidone palmitate Quetiapine fumarate	Risperidone Risperidone microspheres Ziprasidone HCL Ziprasidone mesylate
Combinations	Olanzapine-fluoxetine HCL (Symbyax)	Perphenazine-amitriptyline HCL (Etrafon, Triavil [various])	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Administrative Specification

Denominator The eligible population.

Numerator Both of the following during the measurement year.

- At least one test for blood glucose (Glucose Tests Value Set) or HbA1c (HbA1c Tests Value Set).
- At least one test for LDL-C (LDL-C Tests Value Set) or cholesterol (Cholesterol Tests Other Than LDL Value Set).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APM-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	For each age stratification and total
Reported rate	For each age stratification and total
Lower 95% confidence interval	For each age stratification and total
Upper 95% confidence interval	For each age stratification and total

Appendix C: Draft Document for HEDIS 2015 Public Comment Technical Specifications (for Performance Indicators 4-6)

Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents

Description

The percentage of children and adolescents 0–17 years of age who were on antipsychotic medication and who received two or more antipsychotic medication prescriptions with higher-than-recommended doses.

Note: *A lower rate indicates better performance.*

Eligible Population

Product lines: Commercial, Medicaid (report each product line separately).

Ages: 0–17 years by December 31 of the measurement year. Report four age stratifications and a total rate:

- 0–5 years.
- 6–11 years.
- 12–17 years.
- Total

The total is the sum of the age stratifications.

Continuous enrollment: 90 days or more.

Allowable gap: None.

Anchor date: December 31 of the measurement year.

Benefit: Medical and pharmacy.

Event/diagnosis: At least two antipsychotic medication dispensing events (Table XXX-A) on different dates of service during the measurement year.

Administrative Specification

Denominator: The eligible population.

Numerator: Received two or more prescriptions for an antipsychotic medication in the measurement year with higher than recommended doses.

Higher-than-recommended dose is a dispensed antipsychotic that meets "average daily dose" criteria in Table XXX-A.

Note: For medications in Table XXX-A, identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org).

Table XXX-A. Antipsychotic Medication Dose Maximums

Antipsychotic	Average Daily Dose Criteria for <13 years	Average Daily Dose Criteria for 13–17 years
Aripiprazole	>15 mg/day	30 mg/day
Asenapine maleate	>20 mg/day	>20 mg/day
Chlorpromazine hcl	>500 mg/day	>800 mg/day
Clozapine	>300 mg/day	>600 mg/day
Fluphenazine hcl	>10 mg/day	>10 mg/day
Haloperidol	>6 mg/day	>10.5 mg/day
Iloperidone	>24 mg/day	>24 mg/day
Loxapine	>100 mg/day	>100 mg/day
Lurisadone	>80 mg/day	>80 mg/day
Olanzapine	>12.5 mg/day	>20 mg/day
Paliperidone	>15 mg/day	>15 mg/day
Perphenazine	>6 mg/day	>64 mg/day
Pimozide	>10 mg/day	>10 mg/day
Quetiapine fumarate	>300 mg/day	>600 mg/day
Risperidone	>3 mg/day	>6 mg/day
Thioridazine hcl	>120 mg/day	>210 mg/day
Thiothixene	>20 mg/day	>20 mg/day
Ziprasidone hcl	>160 mg/day	>160 mg/day

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table XXX-1/2: Data Elements for Use of Higher than Recommended Doses of Antipsychotics in Children and Adolescents

	Administrative
Measurement year	X
Data collection methodology (Administrative)	X
Eligible population	For each age stratification and total
Numerator events by administrative data	For each age stratification and total
Reported rate	For each age stratification and total
Lower 95% confidence interval	For each age stratification and total
Upper 95% confidence interval	For each age stratification and total

Follow-up Visit for Children and Adolescents on Antipsychotics

Description

The percentage of children and adolescents 0–17 years of age who had a new prescription for an antipsychotic medication and had one or more follow-up visits with a prescriber.

Definitions

Intake Period: The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.

New Episode: The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.

Negative Medication History: A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

IPSD: Index Prescription Start Date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.

Eligible Population

Product lines: Commercial, Medicaid (report each product line separately).

Ages: 0 years as of March 1 of the year prior to the measurement year to 17 years as of February 28 of the measurement year. Report four age stratifications and a total rate:

- 0–5 years.
- 6–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment: Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Allowable gap: None

Anchor date: None

Benefit: Medical and pharmacy.

Event: Follow the steps below to identify the eligible population.

Step 1: Identify all children and adolescents in the specified age range who were dispensed an antipsychotic medication (Table XXX-A) during the 12-month Intake Period.

Step 2: Test for Negative Medication History. For each member identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History.

Step 3: Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4 Required exclusions: Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. An acute inpatient encounter in combination with any of the following meets criteria:

- A principal mental health diagnosis (Mental Health Diagnosis Value Set).
- A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Administrative Specification

Denominator: The eligible population.

Numerator: One or more follow-up visits with a practitioner with prescribing authority, within 30 days after the IPSD.

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- ADD Stand Alone Visits Value Set.
- ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.
- ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Note: Do not count a visit on the IPSD as the follow-up visit.

Table XXX-A. Antipsychotic Medications

First Generation Antipsychotic Medications	Second Generation Antipsychotic Medications
Chlorpromazine hcl	Aripiprazole
Fluphenazine hcl	Clozapine
Fluphenazine decanoate	Iloperidone
Fluphenazine enanthate	Olanzapine
Haloperidol	Olanzapine pamoate
Haloperidol decanoate	Paliperidone
Haloperidol lactate	Paliperidone palmitate
Loxapine hcl	Quetiapine fumarate
Loxapine succinate	Risperidone
Molindone hcl	Risperidone microspheres
Perphenazine	Ziprasidone hcl
Pimozide	Ziprasidone mesylate

Promazine hcl	
Thioridazine hcl	
Thiothixene	
Thiothixene hcl	**Combinations**
Trifluoperazine hcl	Olanzapine-fluoxetine hcl (Symbyax)
Triflupromazine hcl	Perphenazine-amitriptyline hcl (Etrafon, Triavil [various])

Exclusions: None

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table XXX-1/2: Data Elements for Follow-Up Visit for Children and Adolescents on Antipsychotics

	Administrative
Measurement year	X
Data collection methodology (Administrative)	X
Eligible population	X
Numerator events by administrative data	X
Reported Rate	
Lower 95% confidence interval	X
Upper 95% confidence interval	X

Metabolic Screening for Children and Adolescents Newly on Antipsychotics

Description

The percentage of children and adolescents 0-17 years of age who had a new prescription for an antipsychotic medication and had baseline metabolic screening.

Definitions

IPSD: Index Prescription Start Date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.

Intake Period: The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.

Negative Medication History: A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

Eligible Population

Product lines: Commercial, Medicaid (report each product line separately).

Ages: 0 years as of March 1 of the year prior to the measurement year to 17 years as of February 28 of the measurement year. Report four age stratifications and a total rate:

- 0–5 years.
- 6–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment: Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Allowable gap: None.

Anchor date: December 31 of the measurement year.

Benefit: Medical and pharmacy.

Event/diagnosis: Follow the steps below to identify the eligible population.

Step 1: Identify all children and adolescents in the specified age range who were dispensed an antipsychotic medication (Table XXX-A) during the 12-month Intake Period.

Step 2: Test for Negative Medication History. For each member identified in step 1, test each antipsychotic prescription for a Negative Medication History.

Step 3: Determine the IPSD. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History.

Step 4: Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Administrative Specification

Denominator: The eligible population.

Numerator: Both of the following within 90 days prior to 15 days after the IPSD.

- At least one test for blood glucose (Glucose Tests Value Set) or HbA1c (HbA1c Tests Value Set).
- At least one test for LDL-C (LDL-C Tests Value Set) or cholesterol (Cholesterol Tests Other Than LDL Value Set).

Table XXX-A. Antipsychotic Medications

First Generation Antipsychotic Medications	Second Generation Antipsychotic Medications
Chlorpromazine hcl	Aripiprazole
Fluphenazine hcl	Clozapine
Fluphenazine decanoate	Iloperidone
Fluphenazine enanthate	Olanzapine
Haloperidol	Olanzapine pamoate
Haloperidol decanoate	Paliperidone
Haloperidol lactate	Paliperidone palmitate
Loxapine hcl	Quetiapine fumarate
Loxapine succinate	Risperidone
Molindone hcl	Risperidone microspheres
Perphenazine	Ziprasidone hcl
Pimozide	Ziprasidone mesylate
Promazine hcl	
Thioridazine hcl	
Thiothixene	
Thiothixene hcl	**Combinations**
Trifluoperazine hcl	Olanzapine-fluoxetine hcl (Symbyax)
Triflupromazine hcl	Perphenazine-amitriptyline hcl (Etrafon, Triavil [various])

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table XXX-1/2: Data Elements for Metabolic Screening for Children and Adolescents Newly on Antipsychotics

	Administrative
Measurement year	X

Data collection methodology (Administrative)	X
Eligible population	X
Numerator events by administrative data	X
Reported Rate	X
Lower 95% confidence interval	X
Upper 95% confidence interval	X

<Head of Household Full Name>
<Address Line 1>
<Address Line 2>
<City>, <State> <ZIP>

<Date>

Dear Parent/Guardian of <Minor Full Name>:

You and your child are valued members. Together with your doctors, we want to ensure that your family always gets the best health care possible.

We understand your child may have started a type of medication. It is called an antipsychotic medication. It is most often used to treat certain behavioral health conditions. Each step of treatment for such a condition is very important. Your child's doctors and other providers will work together to manage this care closely.

What steps should you take for your child?

The first step in this type of treatment is a full assessment. Your doctor will need to perform certain tests, sometimes called "metabolic" screening. These tests include a Blood Glucose test and a Cholesterol Test. These tests are very important. Have them done before starting the medication. Then continue the tests throughout the course of care. Please contact your child's doctor at the following number if you are unsure if your child has had these tests or if you need to schedule an appointment for these tests:

Dr. <Provider_Last_Name> at <Provider_Phone_number>

Your child's doctor will need to see your child **within 30 days** of starting the medication. This is to make sure the medication is working properly. Also remember to keep the appointments with your child's doctors. Finally, it is also very important that your child see a mental health provider, sometimes called a therapist. He or she will work with your child and family to address your child's symptoms. Please schedule an appointment with a therapist as soon as possible if your child has not seen one already.

Questions? Need help with appointments?

If you need help in finding a mental health provider/doctor or with scheduling any appointments, WellCare can help. Please call Customer Service at **1-877-389-9457** (TTY **1-877-247-6272**). We are here for you Monday–Friday, 7 a.m. to 7 p.m. Eastern Time.

WellCare of Kentucky also has a Behavioral Health Crisis Hotline that can answer your behavioral health questions or concerns. Please call **1-855-661-6973** (TTY **1-877-247-6272**). There is no charge for this. You can call any time, day or night.

Sincerely,

WellCare of Kentucky

Appendix E: Educational Provider Mailing Letter Template

<Rx_Provider_FirstName> <Rx_Provider_LastName>
<Address Line 1>
<Address Line 2>
<City>, <State> <ZIP>

<Date>

Dear <Rx_Provider_FirstName> <Rx_Provider_LastName>,

WellCare of Kentucky is undertaking a statewide initiative focused on improving the care of pediatric members who are being treated with an antipsychotic medication. A review of our records indicates that your patient, <Member_FirstName> <Member_LastName> (DOB: <MM/DD/YYYY>), recently filled a new prescription for an antipsychotic medication.

WellCare Health Plans supports the position paper of the American Academy of Child and Adolescent Psychiatry (AACAP) entitled, "Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents." The full AACAP Practice Parameter, including clinical evidence base and recommendations, can be accessed at the AACAP website via the following link:
www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf

Additionally, an "Assessment, Screening and Monitoring Tool for Pediatric Members Prescribed an Atypical Antipsychotic Medication" is available for our providers as a resource. It can be accessed at the following site:
kentucky.wellcare.com/WCAssets/kentucky/assets/KY_CAID_PRO_AntipsychoticAssessmentTool_02_2015.pdf

WellCare of Kentucky values quality, coordination and continuity of care for all members. We encourage you to review the full AACAP practice parameter and download a copy of the WellCare tool to assist you in managing your pediatric patient's treatment with an antipsychotic medication. If you would like more information regarding this initiative, please feel free to contact Cheryl Herre, Quality Improvement Project Manager, at **1-502-253-5191** or via email at **Cheryl.Herre@wellcare.com**.

Sincerely,

WellCare of Kentucky

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8/31/2015	
Dept	All
MGR	All
SPV	All

Group	Manager	Report Date	Groups		Categories	6/1	6/8	6/15	6/22	6/29	7/6	7/13	7/20	7/27
Case Mgmt.	Mgr 1	8/31/15	CCM	Productivity	% of Pending OOC (Out of Compliance)									
					Newly Opened Cases w/ Assmt. & CP									
					# of Cases in Open Status									
					# of Cases to Hit 100% to Goal									
					% of Cases in Open Status to Goals									
					% Monthly Round Up Towards Goals									
					Cases Closed									
				Audits	Final Score	93%					93%			
			SCM	Productivity	% of Pending OOC (Out of Compliance)									
					Newly Opened Cases w/ Assmt. & CP									
					# of Cases to Hit 100% to Goal									
					% of Cases in Open Status to Goals									
					% Monthly Round Up Towards Goals									
					Cases Closed									
				Audits	Final Score	94%					93%			
			BH	Productivity	% of Pending OOC (Out of Compliance)									
					Newly Opened Cases w/ Assmt. & CP									
					# of Cases in Open Status									
					# of Cases to Hit 100% to Goal									
					% of Cases in Open Status to Goals									
					% Monthly Round Up Towards Goals									
					Cases Closed									
				Audits	Final Score	93%					95%			
Disease Mgmt.	Mgr 2	8/31/15	DM	Productivity	% of Pending OOC (Out of Compliance)									
					Newly Opened Cases w/ Assmt. & CP									
					% of Cases in Open Status to Goals									
					% Monthly Round Up Towards Goals									
					Cases Closed									
				Audits	Final Score	93%					95%			
Care Coordination	Mgr 3	8/31/15	Coord	Productivity	% of Pending OOC (Out of Compliance)									
				Audits	Final Score	97.0%					98.0%			

SECTION IV.X TRANSITION AND IMPLEMENTATION

116. Describe how the MCO will coordinate the initial transition of individuals in the follow situations to ensure continuity of care:

- From another MCO.
- From FFS , including specific approaches for the aged and disabled populations who are new to managed care.

Include processes for engaging existing providers in the transition.

(Page limit 5 pages)

WELLCARE'S MEMBER FIRST PHILOSOPHY: TRANSITIONS AND CONTINUITY OF CARE

WellCare is a leader in helping members transition from other MCOs and the Fee-for-Service (FFS) Medicaid system, particularly for individuals with complex conditions. We view transition of care as a continuous process where we aim to improve health care quality, mitigate complications, eliminate unnecessary costs, and improve member satisfaction through identification, engagement, assessment, and care coordination.

Our documented, well-established, proven process for facilitating the seamless transition during initial enrollment that we will use in Nebraska is based on NCQA standards for Continuity and Coordination of Medical Care. We will develop a specific Heritage Health Member Transition Policy, which will be based on similar policies in use in other states including ones that have been externally validated by NCQA.

Setting the Standard for Proper Transitions

One WellCare affiliate, Missouri Care, developed a transition of care form that became the basis of the Missouri HealthNet Division transition of care form now used by all Medicaid MCOs in the state.

Our transition of care activities support a variety of diagnoses including pregnancy and behavioral health-related conditions and specifically assist members with more challenging needs, including their non-clinical needs, and including those members in the Aged, Blind and Disabled (ABD) as well as Foster Care populations. In Nebraska, we are particularly sensitive to both of these populations as well as members living in rural and frontier communities who have not had a diversity of plans prior to the implementation of Heritage Health. The following is a high-level summary of the processes we use to ensure continuity of care for members:

Identify Members in Need of Transition Support

We provide for the timely identification of members in need of transition of care support through a variety of channels including special flags in the state's 834 eligibility file, state notification, transferring health plan notification, customer service, welcome calls, enrollee self-referral, care giver referral, and provider referral.

During the initial implementation in Nebraska, we will work closely with MLTC to ensure members are appropriately flagged for transition support. Additionally, our member onboarding and welcome processes described in the Member Services section of this response will include identification of members with higher touch care management needs such as children in residential care or recently transitioned from residential care, to assist with transition needs.

Transitioning from another MCO: WellCare of Nebraska is eager to work with other MCOs in the state to have a consistent and streamlined process for identifying members in need of extra transition care.

Transitioning from FFS: Many ABD members will need additional help during transition and identifying those who need the most coordination is an important step to ensure members don't fall through the cracks. WellCare of Nebraska would like to work with MLTC to use claims data in the FFS system to identify members most in need of transition care management services, including examining pharmacy data since large numbers of medications can be an indicator of specialized care management needs. During implementation meetings across the state, we'll also provide tools for members, providers and advocates to refer to transition care if there is a particular concern about making sure a member new to Managed Care is identified and engaged early.

Reach & Engage Members to Streamline the Transition Process

Once a member is identified, a care manager attempts to outreach the member and the member's primary provider to inform them of their new contacts with the health plan, confirm the member's current health care/service needs, and provide support and assistance to the member during this transition of care process. Care management staff will identify any possible barriers that would prevent a successful transition, including, but not limited to initiating processes for a member if he or she is receiving services from a provider not contracted with WellCare, following up with home health agencies or DME providers if needed so there is no interruption of services. Care management staff will also complete an assessment to determine if there are any new or urgent health care needs. If it is determined that the member needs assistance with coordination of care, the care manager will work with all involved parties, including providers, specialists, previous care managers, and other organizations that the member may be receiving services from through waiver programs or school based services to make the transition as successful as possible.

WellCare of Nebraska's model to place field-based care managers, as well as welcome rooms, in communities across the state is also an important tool to ensuring we can reach and engage members identified as being in need of transition services. Additionally, WellCare's Health*Connections* model serves as another arm of support for members who may not be reached through traditional means. Our relationships with social safety net providers across the state and Nebraska CommUnity Advocacy team gives us additional outlets to engage members in ways that are culturally competent to meet their unique needs. In addition, WellCare leverages the relationships with our community partners that we establish through the Health*Connections* Model to share important updates about the Heritage Health program that learn from the state.

Transitioning from another MCO: We would encourage MCOs to work together in the best interest of the member to share contact information and any nuances around challenges reaching members and their caregivers. For all members and their caregivers, WellCare helps members resolve social barriers as well during and after their transition in to Managed Care.

Transitioning from FFS: When we met with members in Nebraska's ABD population, most of whom were dually eligible for Medicare and Medicaid, it was clear that members need to be engaged in ways that meet them where they are, so they can fully understand the benefits and services available to them under their health plans. For those with Behavioral Health needs, for instance, we will use peers to help engage harder to reach and engage members. For all members and their caregivers, WellCare helps members resolve social barriers as well during and after their transition in to Managed Care.

Assess and Coordinate for Specific Member Needs

Once it is determined that a member is transitioning, the care management staff notifies the member, providers and the receiving managed care organization, if applicable. A transition of care form is completed by care management staff and sent to all parties. The form includes member's diagnoses, medications if known and any additional information that will be helpful to transition the member. If a member is enrolled in care management, the care manager attempts to make contact with the member via phone to discuss transition processes. If a member has any urgent needs that will require assistance from

the receiving health plan, the care manager will attempt to contact the care manager to assist with the transition in order to limit any interruptions of care. ***These assessment processes remain stable regardless of where the member transitions from.***

Transitioning Pharmacy for Members

WellCare Pharmacy believes that continuity of care, especially during a transition period from FFS or another MCO is critical to maintaining the health and well-being of our members. WellCare will follow MLTC requirements and continue to transition a member on their medication for up to 90 days. Thereby allowing the member and their provider adequate time to either request a Drug Exception Review (DER), prior authorization, to continue their current treatment for as long as it is medically necessary or to switch to a medication that is on the Nebraska Medicaid PDL. Once historical data is made available to WellCare, this information would be used along with information provided by the prescriber to make the decision on the DER. WellCare pharmacy is dedicated to providing the right medication to our members throughout the transition period and beyond.

Engaging Technology to Share Information and Ensure Seamless Transitions

WellCare has extensive experience working with different states on unique formats for sharing information to aid in transitions. The information we receive from another MCO or other payer relinquishing a member is typically claims history data used for the purpose of identifying members enrolled in a case management program. We also solicit care plans and treating provider's contact information from the previous payer. We have systems that accommodate obtaining Health Risk Assessment information via an 834 enrollment file.

In Nebraska, we have identified an opportunity to enhance the effort to share information that could be particularly beneficial for members transitioning into and out of different health plans. We believe the Nebraska Health Information Initiative (NeHII) can play a valuable role in the transition of care by offering access to clinical records. NeHII currently holds or accesses records from a large and growing share of the hospitals and providers in Nebraska. WellCare was invited to provide input to the NeHII Strategic Planning meeting on October 2, 2105 where we encouraged NeHII to allow and encourage MCOs to provide information to the network. This additional information would further smooth a member's transition, not only between or to MCOs, but between providers and health homes as well. This information, in machine-readable form, would not only aid care managers and providers but could be used in Population Health management programs to ensure the right treatment is available at the right time.

Additionally, on an ongoing basis, WellCare plans to leverage our proprietary Health*Connections* Model through which we monitor social service access and use maintained at a member-level in a social service electronic health record. Anticipated uses of the data from the Health*Connections* Model includes the transition of members into different care settings, effective social service network planning to ensure the availability of services when needed, deeper population health management, and more.

Coordinating Care and Engaging Existing Providers in the Transition

Our highly trained care managers coordinate with the member's prior health plan, if applicable, and work diligently to maintain existing care plans which include continuation of prescheduled services, including those with out of network providers. The care management staff determines any transition of care needs, such as a member who is receiving home health services or equipment from a DME provider. The care management staff attempt to notify these providers and assist with the authorization process if needed so that there is no interruption in services that the member may be receiving. Additionally, care management engages the member's existing PCP, whether it's a contracted provider or not, to ensure they are aware of and are involved in any changes to the member's care plan. Care managers work to ensure minimal to no disruption in the care plan unless requested by the member, caregiver, PCP or other provider and it is

agreed that the change is in the member's best interest.

Our transition of care policies provides for continuation of and payment for prescheduled health services. WellCare knows that enrollees in transition have existing prior authorizations from either the incumbent health plan or the fee-for-service program. To enable a seamless transition, we cover the cost of continuation of medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out of network providers for 90 days or up until transition to an in-network provider is safely completed.

This is particularly important for our pregnant members transitioning over to ensure they remain connected to pre-natal services. In addition to enabling pregnant members to receive services from their prenatal care provider, WellCare recognizes the criticality of medical and behavioral health co-existing conditions, especially as it pertains to pregnant members with behavioral health and/or substance abuse issues, as well as with social issues. Our transition of care policy and procedures will also allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.

SUCCESSFUL TRANSITIONS

A Success Story from WellCare's Missouri Care Affiliate

In September 2012, a 17-month-old female enrolled in the Missouri Care health plan. The member was a twin who was born late-preterm at 34+ weeks and unknowingly exposed to RSV, after which she developed significant problems due to prolonged resuscitation efforts in the emergency department. As a result, the member now has developmental delays, feeding difficulties, breathing issues and possible heart complications. The member's mother, outreached to care management prior to the member's eligibility effective date. A care manager was assigned and immediately began working with the mother towards a smooth transition. At the time of initial contact the family was living in the Kansas City area using providers to meet their needs. The member was admitted to the hospital in Kansas City right before her first birthday with increased respiratory effort & fluid build-up. She was transferred to St. Louis to be seen by a pediatric cardiology specialist the day after her 1st birthday. She remained hospitalized for a little over 2 months while efforts were made to stabilize her condition & decrease her medication needs. During her hospital stay care management worked with the member's mom, management and hospital staff to meet the family's lodging and meal needs, as the travel distance between home and the hospital exceeded the 120 mile limit, and to develop a discharge plan. Prior to the member being discharged, care management worked with the member's mom to identify a high-risk pediatrician nearby for ease of follow-up. The care manager also worked with prior authorization and utilization management teams to make sure continuity of care was maintained by having visits for out-of-network providers approved prior to visits.

SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

117. Provide a detailed description of the MCO's approach to implementing the necessary functionality to support FFS claims processing.

WELLCARE'S APPROACH TO SUPPORT FEE-FOR-SERVICE CLAIMS PROCESSING

WellCare plans to leverage decades of experience and technical expertise in claims processing, data management and IT systems and infrastructure to support the state's fee-for-service (FFS) claims processing needs. WellCare has been successfully operating in nine Medicaid programs in addition to our Medicare Advantage and Part D products. The Nebraska claims broker services will be operated as a separate line of business (LOB), and we are confident that our robust process will meet all the requirements as outlined in *Section Z Claims Management and Processing* of the SOW.

WellCare understands that we must maintain the same functionality for FFS claims that is required for our managed care claims as described in *Section S. Claims Management* of this RFP. The following paragraphs discuss in detail our existing functionalities that we use for managed care claims and plan to leverage for FFS claims processing or claims broker services.

In our strategy to implement the necessary functionality to support FFS claims processing, we will approach the claims broker service once MTLC identifies the formal transition date with the same standards of rigor and project management governance, as well as long-term operational support as we use to manage the risk business. We have already developed a draft implementation plan, and are prepared to collaborate with MLTC, other health plans, the enrollment broker and the state's FFS providers to develop a smooth process for transitioning services to a claims broker.

Claims Processing

The mission of our claims department is to serve our members and providers through consistent, prompt and accurate payment of claims. Through daily monitoring coupled with our integrated tools and technology, WellCare has demonstrated continuous improvement in the claims processing system. Our claims department conducts numerous independent audits to identify opportunities to eliminate defects on a pre-payment and post-payment basis. These include targeted audits, peer reviews, hospital audits, external department audits and pre-payment high dollar audits.

Our claims team monitors the claims activity performance on a daily basis through workflow management tools, such as Claims Processing Report (CPR) to manage inventory and turnaround time reports. This ensures that claims are processed in accordance with all applicable regulatory timeframes. All claims received pass through a series of Strategic National Implementation Process (SNIP) edits to ensure accurate adjudication of benefits and payment. The claims which successfully pass these edits are loaded to our Core Processing System (CPS) for final adjudication and payment.

WellCare understands, acknowledges and will comply with the HIPAA national standards related to FFS claims processing including, but not limited to, electronic transactions standards for MLTC. With this robust, centralized, integrated system we will monitor and manage the claims intake and processing flow, including a complete, daily end-to-end reconciliation process for our FFS claims.

Claims Dispute Management

We have policies and procedures that allow providers to submit a request for adjustment to previously denied or underpaid claims. The claims payment dispute process is designed to address claim denials/ payments for issues related to a claim denial for timely filing, pricing, coding or billing related issue not tied to medical necessity, and to dispute the amount paid on a claim. Providers can call, email or mail their claim disputes. WellCare will address and close any disputed claims within 30 business days. The claim dispute will be documented, acknowledged and entered into our dispute inventory to be completed.

Provider Services

WellCare's provider experience has enhanced over the years and we will continue this effort in Nebraska for FFS claims. As mentioned in *Section J. Provider Services*, we will operate a dedicated toll-free provider services telephone line. This line will be available to our providers at all times for inquiries regarding authorizations, member eligibility, demographic changes, claims status, benefits, questions, concerns or complaints. The provider services telephone line will be staffed by highly trained associates with broad-based experience handling provider calls specific to Nebraska. Our provider service line will be manned Monday through Friday from 7:00 a.m. –8:00 p.m. central time, except for state holidays, to address non-emergency provider issues, and anytime for non-routine prior authorization requests and emergent provider and pharmacy issues. Clinical pharmacists will be available Monday through Friday 8:00 a.m.-8:00 p.m. central time for clinical questions and prior authorization processing.

Our secure provider portal allows providers to process authorizations 24/7. All our provider notifications, bulletins, newsletters, FAQs and other pertinent information will be available to providers participating in the FFS program. All our communication efforts will be specific to the claims broker services, branded as such and clearly and distinctly separate from the risk business.

Member Services

WellCare recognizes that the State will retain responsibility for enrollment of and communication with members in the FFS program, and the FFS claims broker services are to be focused on the claims-related aspects of *Section Z Claims Management and Processing* of the SOW. However, WellCare is prepared to respond to any member services needs that arise through our work as the FFS claims broker and welcomes conversations with MLTC about the division of roles through this project.

Payment to Providers

As stated in the SOW, WellCare will pay the FFS claims at a fee schedule rate as set by MLTC and on a schedule and frequency agreed upon with MLTC.

Remittance Advice

WellCare generates remittances electronically using 835 files. These transactions are submitted to our vendor (PaySpan) for execution. Completed transactions are returned for tracking, reconciliation and final payment verification. Providers unable or unwilling to utilize electronic formats are accommodated by PaySpan with paper documents produced from these electronic transactions or the ability to download remittance advices directly from their web portal.

Prior Authorization

Prior authorization is the process of obtaining approval from WellCare in advance of providing a covered service. Our Utilization Management (UM) uses prior authorization to help ensure: 1) the efficient use of covered services; 2) that members receive the most appropriate level of care; and 3) that care is delivered within the most appropriate setting. UM does not require prior authorization for emergency services and urgent care center services. WellCare will leverage our standard PA process for services paid as FFS in accordance with the Nebraska Medicaid policy. WellCare's FFS claims will be paid or denied with FFS authorization policies.

Grievance and Appeals

WellCare's Medicaid grievance system complies with Federal and State regulatory requirements and includes processes to receive, process, and report on member grievances and appeals. Our internal review process, which provides one level of appeal, allows members and providers to present new or additional information about the member's health so we may evaluate previously denied, reduced, or suspended services. As required, our grievance system includes access to the State's fair hearing system allowing members and providers at any time to appeal WellCare's decision to uphold the denial.

Our fully-functioning grievance and appeals system that we use for our risk business will be in place as a separate and distinct function for the FFS business.

Third Party Liability and Recovery

Our claims broker service will develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for the FFS members. We will perform cost avoidance and third party liability collection activities under well-defined policies and procedures that conform to federal and state of Nebraska requirements. The coordination of benefits, or cost avoidance process begins with updating member records to include information on other insurance. This is utilized during claims payment as we send monthly claims and eligibility data feeds to our vendors to evaluate and determine if any members have other coverage through a commercial source. Once the analysis is completed, the vendor sends a return file containing other insurance information for use in updating our member eligibility files. We send the TPL files (new or updated) to the State.

Our Audit and Recovery department creates monthly reports that contain claim avoidance information for any member where a primary payer is responsible. We report COB savings or cost avoidance for claims in two categories: 1) claim is denied payment for primary insurance carrier explanation of payment; or 2) claim is paid as secondary by WellCare as primary insurance carrier explanation of payment was attached by provider.

Drug Rebates

WellCare intends to leverage our unique hybrid pharmacy model with a number of critical pharmacy benefit management functions performed in-house by WellCare personnel, coupled with the activities of a pharmacy benefits manager (PBM), for providing the state of Nebraska pharmacy claims information. Using the Nebraska Medicaid Preferred Drug List (PDL), WellCare will provide formulary coverage, at a minimum, for all classes of drugs including over-the counter (OTC), to the same extent they are covered by the Nebraska Medicaid Fee-For-Service (FFS) pharmacy benefit. We use a well-defined database MediSpan for pharmacy claims processing, updating schedules, term dates, obsolete dates and rebate status.

SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

118. Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.

WELLCARE'S PROCESS OF HANDLING CHANGES IN POLICY AND PROCEDURE FROM MLTC

WellCare understands that to be successful in Nebraska with the claims broker line of business (LOB), we must have a thorough knowledge of the existing program and policies, monitor for identified changes in the policies and programs and maintain a comparative analysis of the changes to the existing programs and policies. Our level of effort is dependent on the amount of change required.

Any program change is managed by WellCare's Enterprise Project Management Office (ePMO) Market Initiatives team who assists in coordinating efforts as well as documenting and tracking milestone dates to ensure updates are made on-time. The ePMO's involvement begins early on with the selection of a senior project manager who monitors the RFP process to determine any significant changes to "People, Processes and Technology" associated with the assumptive requirements of the contract based on the RFP. Our PMP-certified, professional project managers leverage ePMO-developed, best-practice "Playbooks" that reflect years of industry experience and aggregate lessons learned across numerous contract implementations.

The project manager develops a high-level scope document, Microsoft® Project work plan, resource plan, organizational chart, budget and risk document. The project manager introduces these artifacts with the broader team at the project kick off meeting and continually refines them as the project progresses into later stages. The process is underscored by a cadence of regularly scheduled internal Steering Committee, Work Group, Status, Issue/Risk and Change Control meetings. The goals of successful management of any project or change include, but are not limited to, ensuring the following:

- Effective communication
- Timely project delivery
- Issue resolution
- Scope control
- Escalation to appropriate parties when necessary.

New Covered Service

Any change in covered services is managed by our Product Development and Strategy department (Product). Product drives the initiative to ensure that the claims system is appropriately updated and configurations of all related rules are in place so claims for the new process are processed effectively. We also have the ability to work with MLTC to assist with any communications and required notifications to providers and/or members as needed.

Prior Authorization

Once Utilization Management (UM) or prior authorization leadership is informed or notified, the task of updating the authorization look-up tool, the Quick Reference Guides, policies/procedures and step actions are completed by specially-trained project analysts. Where prior authorization is required, we have project management process to configure our systems to reflect the requirement through to clams editing. The associates are then informed of the changes and any needed training is completed prior to the implementation of the changes.

Additional Populations

In situations where additional populations will be added to the Nebraska Medicaid FFS program, the main

strategy of WellCare will be to ensure we have resources to manage the additional influx. Our systems are designed with flexibility for bolt-on programs and populations without a complete redesign. Rather, we would use our change/project management process to configure for new populations in collaboration with MLTC and the enrollment broker to align benefits and services to the population need.

SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

119. Describe how the MCO will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.

WELLCARE'S INTEGRATED MANAGEMENT INFORMATION SYSTEM

WellCare's single-instance, fully integrated IMIS platform is scalable and flexible. It is used to collect, analyze, integrate and report data in support our entire operating book of business covering more than 3.7 million members for various lines of business and health plan operations, including Medicare Advantage in 15 States, Medicaid contracts in nine States, Part D operations in 33 Regions (49 states and the District of Columbia), and two Health Insurance Exchange markets. WellCare will leverage IMIS suite to support all the aspects of our processing requirements for both distinct lines of business (LOBs), including those specified in the *Section S. Claims Management* of the SOW.

Because we use this single-instance platform to support a large number of diverse government contracts, we have designed it to ensure it easily supports the addition of LOBs. The general structure and components of our systems architecture is detailed in **Figure 1**.

Through the use of a distinct LOB to represent each unique contract with a government agency, the IMIS enables each individual contract to maintain different rules for claims processing (including pricing and adjudication rules), separate and distinct benefit packages, unique provider contracts and directories, separate membership rosters, unique prior authorization rules and all other forms of operating rules. The IMIS suite is designed and built to leverage configuration changes by business users which permit them to modify, enhance and improve the behaviors and functionality of the applications. As a result, these operating rules are configurable by LOB and do not require software deployments, enabling rapid, secure, and effective administration of multiple government contracts in a single instance solution.

Leveraging the Architecture and Design of WellCare's IMIS System

Our integrated platform is capable of creating a clear distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system. There are several advantages of leveraging our IMIS, which includes but is not limited to:

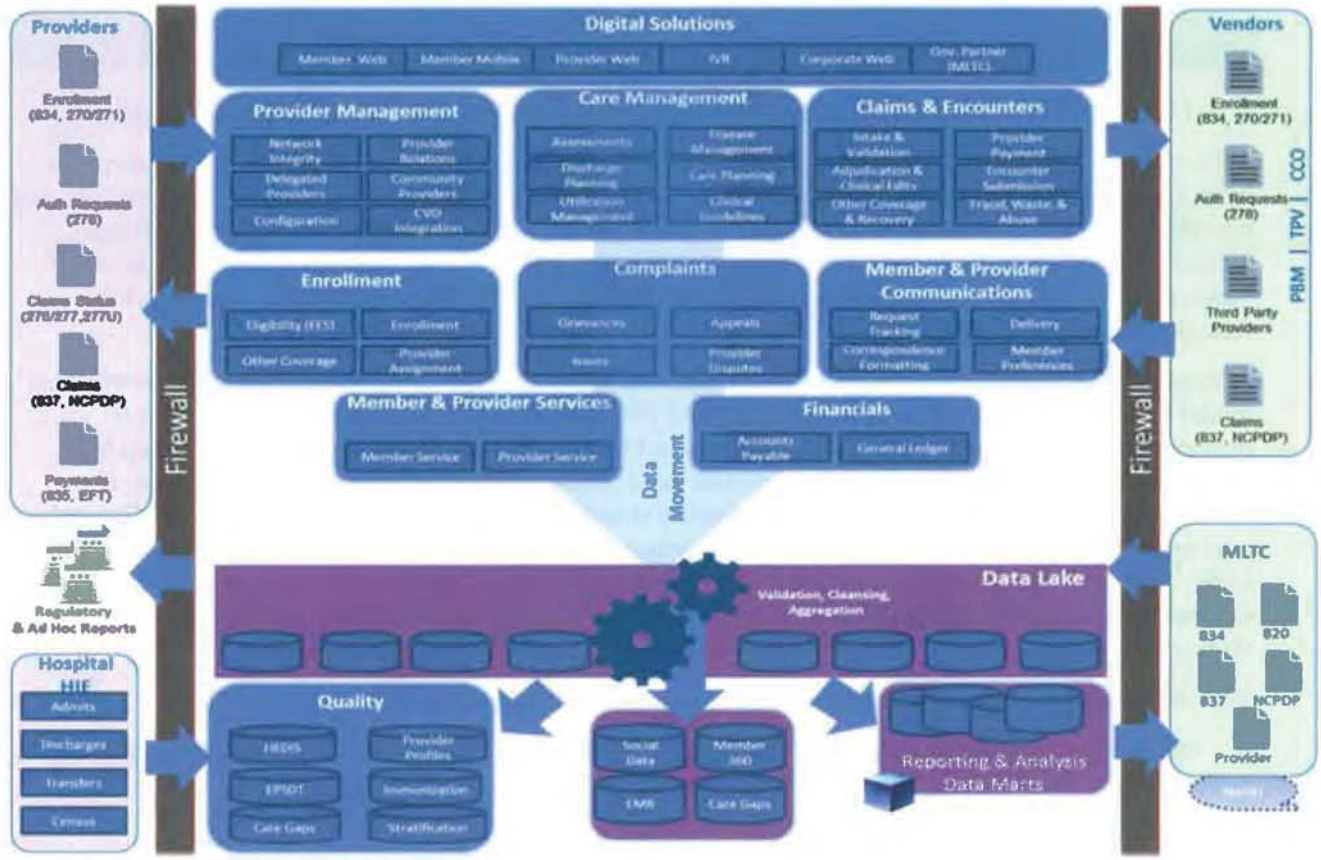
- The Line of Business (LOB) implements the concept of separate, distinct contractual arrangements.
- The support and implementation of the claims management requirements will be established by creating a new LOB in our IMS specifically dedicated to the FFS claims broker services.
- Using this capability, the system will maintain distinct processing rules, benefit structures, provider contracts, and member eligibility that are unique to the FFS claim management LOB.
- All the claims, authorizations, provider payments and all other transactions performed will be within that claims management LOB and distinct from all other lines of business.
- All existing applications and functionality are available to support the FFS contract without new development, while allowing for customizations of items such as logos, ID Cards, and Handbooks

Having a Unique Brand Name

WellCare also associates a distinct brand name and logo to each unique LOB, with the result being that all external communications will have a distinct brand name and logo which helps in preventing confusion

for members and providers. The requirement to provide separation and maintain uniqueness between the Heritage Health and FFS claims processing contract presents no unique issues or concerns to WellCare.

Figure 1



SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

120. Provide an explanation of the MCO's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?

WELLCARE'S APPROACH TO BUSINESS OPERATIONS TO SUPPORT CLAIMS BROKER SERVICES

After reviewing *Section Z Claims Management and Processing* of the RFP, WellCare has developed a hybrid approach to support the fee-for-service (FFS) line of business for Nebraska MLTC. Generally, our operational approach is to establish a distinct Line of Business (LOB) for Nebraska's Claims Broker services and treat it as if we were developing a new health plan or LOB, but with some of the same accountabilities to ensure a streamlined process for MLTC to work with us from the perspective of relationships and accountability.

Because of our experience serving both Medicaid and Medicare members, we have experience with this model in states where we have both Medicaid and Medicare plans. While they are unique lines of business and have distinct operations to ensure one LOB doesn't get lost in the other, leadership has accountability for both LOBs to ensure the state does not develop unnecessary silos. To support the operations, we will leverage our existing corporate shared services structures and allocated staff members who have the expertise and experience to best manage the specific requirements of the Claims Broker LOB. To support leadership, we will hire a local liaison for the Claims Broker business who will provide dedicated local support and provide that local separation between the risk-based business and the Claims Broker business.

To achieve the necessary operational distinctions, we would take the following critical steps:

- Manage the operational support for the each LOB along functional structures (e.g. claims, provider services, utilization management, etc.)
- Segregate the data and unique operational rules to match the needs of each contract
- Train staff members in the functional areas on the contract-specific items and activities

As discussed in Q119 in detail, our single-instance, integrated, enterprise IMIS as the core Information Technology (IT) platform will support both the risk-based and FFS contracts, using a separate Line of Business (LOB) for the two contracts. All operational areas, such as claims processing and customer service, would also be implemented in the same functional areas for both risk based and FFS processing.

Though it will be built in our existing infrastructure, separate and unique operating rules will be implemented to support the uniqueness of the FFS contract. For example, the allocated customer service staff would use WellCare's CareConnects application, with call scripts tailored to this new LOB, for each of the risk based and FFS contracts.

SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

121. Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.

IDENTIFYING POTENTIAL RISKS IN OPERATION OF CLAIMS BROKER SERVICES.

WellCare has carefully considered the potential risks associated with having one of multiple MCOs operate as a claims broker for the remaining fee-for-service (FFS) Medicaid business. We will collaborate with MLTC to take necessary steps for mitigating any issues.

The primary risk associated with having a single entity process both risk-based and FFS contract is the potential for member and provider confusion. We understand that a possible risk would be for providers who operate in both the FFS and the managed care environment and would require them to have a distinct understanding of when to submit the claims to a MCO and to the claims broker.

MITIGATION

WellCare's strategy for mitigating this risk is also inherent in our approach to implementation, with a unique Line of Business (LOB) being established for each of the two contracts. We are offering an integrated, scalable and flexible system to meet the requirements of the claims broker business. Our integrated system will uniquely brand all operations for each of the risk-based and FFS contracts. Any external communications will have a distinct brand name and logo which help in preventing confusion for members and providers. This will help in separating and maintaining uniqueness between the risk-based and FFS claims.

Mitigating Provider Confusion

We believe the greatest risk to the claims broker service will be provider confusion. Some providers will work within both systems and will need robust educational outreach to understand WellCare's role in each. In collaboration with MLTC, We will use the same strategies we deploy for implementing new plans to partner with MLTC to conduct thorough outreach to mitigate this confusion.

Provider Network Preparation for Claims Broker Services

We would recommend partnering with MLTC to invite all providers to attend statewide orientation sessions, and we will offer the same curriculum through multiple delivery modalities including classroom training, online, and video training, to educate as many providers about our FFS members and their distinction with our managed care members.

Our FFS Provider Support Approach During Go Live

WellCare will also use best practices from other WellCare implementations to facilitate the smooth transition of members into the claims broker services plan. At program go-live and continuing for the first four weeks beyond implementation, a team of associates will be available in a Command Center environment to respond immediately to provider questions and facilitate the prompt resolution of any issues.

Additionally, we will use a number of proven strategies for ongoing communications and support of providers including some of the following in **Figure 2**.

Figure 2

PROVIDER SERVICES INFRASTRUCTURE	
Infrastructure	**Activity**
Integrated Contact Center	WellCare will operate an integrated provider services contact center with a unique brand to respond to the needs of our FFS providers. A dedicated toll-free line will be available to our providers for inquiries regarding authorizations, member eligibility, demographic changes, claims status, benefits, questions, concerns or complaints.
Provider website	As an important communication tool, our Nebraska provider website will be branded uniquely to inform, educate and communicate with providers about the FFS claims and WellCare. It will also offer important resources and tools for providers including tools for claim submission, claim status check, prior authorization submission and online training modules.
Collaborating with MLTC	We plan to work with MLTC on leveraging existing provider communication tools the state agency uses to make sure providers are kept up-to-date on ongoing operations of the claims broker services.

SECTION IV.Z CLAIMS MANAGEMENT AND PROCESSING

122. Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.

WellCare fully understands the required timeframe as outlined in *Section Z Claims Management and Processing* of the SOW. In preparation for the readiness review process, we will develop and maintain a detailed implementation plan with the understanding that it is subject to MLTC's approval. This plan will detail tasks, staff responsibilities, timelines, milestones and other processes which will ensure that contracted services begin at the agreed upon date. Our proposed implementation plan is outlined in **Figure 3.**

Staffing structure

WellCare will hire a local liaison staff for the FFS claims in order to avoid any risk-based business.

Task schedule

Key leaders from across our organization have reviewed this new requirement, and have decided to establish claims brokers service as a new LOB in WellCare. Our schedule includes a thoughtful approach to all aspects of services and operations, including recruiting and training internal staff, management of subcontractors, updates to all IT systems, updates to all processes and procedures, enhancements to member and provider outreach programs and materials, and successful completion of readiness reviews.

Figure 3

Task	Months	Start Date	Finish Date
Respond to and submit Nebraska Medicaid RFP	2.48	10/22/15	1/5/16
Analyze RFP responses to determine business requirements, identify IT deliverables and cost estimate, and obtain capital budget approval	5.78	9/12/16	3/6/17
Set Up Project Management Office for the Nebraska Medicaid initiative	5.78	9/12/16	3/6/17
Conduct readiness reviews with MLTC	0.52	10/16/17	10/31/17
Milestone: Operations	13.06	4/3/17	5/4/18
Create BMLs	1.77	9/7/17	10/30/17
Create Benefit Shells	3.10	7/14/17	10/16/17
Create Timely Filing Rules	4.60	7/14/17	11/30/17
Create Benefits configuration based on BML	2.30	9/22/17	11/30/17
Create/Update Authorization screens	2.30	9/22/17	11/30/17
Perform Unit Testing	2.48	10/1/17	12/15/17
Move configuration in test to Production	1.68	11/2/17	12/22/17
Fee Schedules	3.35	9/1/17	12/11/17
Master file updates (DRG)	3.00	9/1/17	11/30/17
Configure & Load Pricing packages (test & production)	3.35	9/21/17	12/31/17
Configure providers in test & production	0.81	12/7/17	12/31/17

Task	Months	Start Date	Finish Date
Configure Pricing Grids	3.06	9/14/17	12/15/17
Post Go Live validation	4.13	1/1/18	5/4/18
Readiness review prep (Claims)	1.77	9/29/17	11/20/17
Update/Create SATs	2.06	9/29/17	11/30/17
Identify staffing requirements	2.43	8/3/17	10/15/17
Create/Update Claims correspondence	3.60	8/3/17	11/20/17
Implement member EOB process	2.75	9/15/17	12/7/17
COB and claims processing	1.97	9/1/17	10/30/17
Establish Failure to Pay (FTP) process (if applicable)	1.97	9/1/17	10/30/17
Establish check run & A/P cycle	1.06	10/30/17	12/1/17
Transition of Care	1.19	10/30/17	12/5/17
EDI Configuration (X-Engine, CIS, Legacy)	4.00	9/1/17	12/31/17
Compliance (policies and procedures)	3.00	7/3/17	10/2/17
End-to End Claims Testing (45 – 60 days prior to go live)	2.16	10/26/17	12/30/17
Perform Legal tasks (vendor and provider agreements and amendments)	6.00	4/3/17	10/2/17
Update subcontractor agreements and systems	6.00	4/3/17	10/2/17
Perform pharmacy formulary updates and update pharmacy operations	1.03	7/28/17	8/28/17
Milestone: Communications	5.06	5/1/17	10/2/17
Develop and execute communication plan	1.03	5/1/17	6/1/17
Update / develop member and provider materials (claims correspondence, NoA letter, etc.)	4.06	6/1/17	10/2/17
Update member and provider portals	3.00	7/3/17	10/2/17
Update CareConnects and call center scripts	3.00	7/3/17	10/2/17
Milestone: Financial	5.94	7/3/17	12/31/17
Update audit and recovery processes and systems	3.00	7/3/17	10/2/17
Perform financial tasks	5.00	8/1/17	12/31/17
Milestone: Regulatory and Reporting	7.97	5/1/17	12/29/17
Update reports based on MLTC report requirements	1.03	5/1/17	6/1/17
Update encounter methodology, update systems, and test	4.06	6/1/17	10/2/17
Update policies and procedures	4.06	6/1/17	10/2/17
Update organizational staff, processes and systems	4.06	6/1/17	10/2/17
Update Appeals and Grievances processes and systems	4.06	6/1/17	10/2/17
Update quality and analytics reporting	6.03	6/1/17	12/1/17
Perform corporate compliance tasks (contract breakdown, Pre-Go Live assessment, Fraud and Abuse activities)	2.90	10/2/17	12/29/17
Develop training for operational staff	1.65	11/1/17	12/20/17
Provide inquiry access to MLTC and train staff	1.94	11/1/17	12/29/17
Milestone: IT	11.03	2/1/17	1/1/18

Task	Months	Start Date	Finish Date
Document requirements	2.10	2/1/17	4/3/17
Document functional system details	2.10	3/1/17	5/1/17
First Release	0.03	10/15/17	10/15/17
Second Release	0.03	12/17/17	12/17/17
Go-Live	0.03	1/1/18	1/1/18

ATTACHMENT 5

2. Provider Contract Template - Submit provider contract template as described in Section IV.I - Provider Network.

Please see Provider Contract Template attached herein.

PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into by and between WellCare of Nebraska, Inc. ("**Health Plan**") and [Insert Name of Contracted Provider] ("**Contracted Provider**"). Health Plan and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

WHEREAS, Contracted Provider provides or arranges for the provision of health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

WHEREAS, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide or arrange for the provision of health care items and services to Health Plan's health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

NOW THEREFORE, the Parties agree as follows:

1. Construction.

1.1. The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2. The following rules of construction apply to this Agreement: (a) the word "**include**", "**including**" or a variant thereof shall be deemed to be without limitation; (b) the word "**or**" is not exclusive; (c) the word "**day**" means calendar day unless otherwise specified; (d) the term "**business day**" means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1. "**Affiliate**" means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity "**controls**" an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

2.2. "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government

Contract. Benefit Plans and their designs are subject to change periodically.

2.3. "**Carve Out Agreement**" means an agreement between Health Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for radiology, laboratory, dental, vision, or hearing services.

2.4. "**Clean Claim**" means a claim for Covered Services that is (i) received timely by Health Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

2.5. "**Credentialing Criteria**" means Health Plan's criteria for the credentialing or re-credentialing of Providers.

2.6. "**Covered Services**" means Medically Necessary health care items and services covered under a Benefit Plan.

2.7. "**DHHS**" means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services ("**CMS**") and its Office of Inspector General ("**OIG**").

2.8. "**Effective Date**" means the date this Agreement becomes effective as determined by Health Plan and set forth on the signature page of this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, the Effective Date is subject to Health Plan's completion of credentialing and determination that Contracted Provider meets the Credentialing Criteria.

2.9. "**Emergency Services**" shall be as defined in the applicable Program Attachment.

2.10. "**Encounter Data**" means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.11. "**Federal Health Care Program**" means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid, and CHIP.

2.12. "**Government Contract**" means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.13. "**Governmental Authority**" means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.14. "**Ineligible Person**" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the System for Award Management maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's

mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

2.15. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("**Medicare**"), XIX ("**Medicaid**") and XXI (State Children's Health Insurance Program or "**CHIP**"), (b) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.16. "**Medically Necessary**" or "**Medical Necessity**" shall be as defined in the applicable Program Attachment.

2.17. "**Member**" means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.18. "**Member Expenses**" means copayments, coinsurance, deductibles, or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.19. "**Non-Contracted Services**" means Covered Services that are (a) subject to Carve Out Agreements and not approved by Health Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

2.20. "**Overpayment**" means the payments a Provider receives from Health Plan or its Affiliates to which the Provider is not entitled, including payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to subcontracted Providers.

2.21. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.22. "**Principal**" means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.23. "**Program**" means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.24. "**Program Attachment**" means an attachment to this Agreement describing the terms of a Provider's participation in Health Plan's provider network for a Program.

2.25. "**Program Requirements**" means the requirements of Governmental Authorities

governing a Provider's participation in Health Plan's provider network and rendering Covered Services to Members pursuant to a Benefit Plan, including where applicable the requirements of a Government Contract, which include those terms set forth in a Program Attachment.

2.26. "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is employed, or directly or indirectly subcontracted by Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.27. "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides, WellCare Companion Guide, and educational materials setting forth Health Plan's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time. The Provider Manual is available on Health Plan's website.

2.28. "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2.29. "**WellCare**" means WellCare Health Plans, Inc., an Affiliate of Health Plan.

2.30. "**WellCare Companion Guide**" means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

3. Scope.

3.1. Non-Contracted Services are outside the scope of this Agreement.

3.2. Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member's medical condition or available treatment options.

3.3. This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4. Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5. Subject to Laws and Program Requirements, Health Plan reserves the right to approve any Provider's participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

4. Provider Responsibilities.

4.1. Principals. Contracted Provider shall comply with requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal Health Care Programs as described in section 1124 of the Social Security Act, 42 CFR part 420 subpart C (Program Integrity: Medicare) and 42 CFR part 455 subpart B (Program Integrity: Medicaid).

Contracted Provider represents that it has provided Health Plan with the information listed on the Attachment titled "Information for Contracted Provider / Principals" for itself and all of its Principals as of the Effective Date. Contracted Provider shall notify Health Plan of any change in the information within 30 days of such change.

4.2. Providers. Contracted Provider shall provide Health Plan with the information listed on the Attachment titled "Information for Providers" for itself and the Providers as of the Effective Date, in a form and format acceptable to Health Plan. Contracted Provider shall provide notice to Health Plan of any change in the information for itself and the Providers within 30 days of the change. When Contracted Provider terminates a Provider, other than for cause, Contracted Provider will give Health Plan at least 90 days prior written notice of the termination.

4.2.1. Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2. Subcontracted Providers. If Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers:

(a) Contracted Provider shall maintain and enforce written agreements with its subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of entire agreements between itself or other Providers and the subcontracted Providers. The compensation terms in such agreements may be redacted unless required by Governmental Authorities. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(b) Upon Health Plan's request, Contracted Provider shall provide Health Plan with a duly executed Opt In Agreement in the form set forth on the Attachment titled "Form of Opt-In Agreement" from each subcontracted Provider. Each executed Opt In Agreement shall be made a part of and incorporated into this Agreement, and Contracted Provider accepts the appointment in the Opt In Agreement to act on the subcontracted Provider's behalf. If Health Plan requests and does not receive a duly executed Opt In Agreement for a proposed subcontracted provider, Health Plan shall not approve the proposed subcontracted provider or its employed providers as Providers under this Agreement. Contracted Provider waives any non-compete provisions in its agreements with subcontracted Providers to the extent that, if enforced, would prohibit a subcontracted Provider from contracting directly with Health Plan pursuant to the Opt-In Agreement.

(c) Subcontracted Providers shall maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(d) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

4.2.3. Credentialing. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3. Covered Services. Providers shall provide Covered Services to Members, subject to and in accordance with the terms of this Agreement.

4.3.1. Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2. Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3. Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization.

4.3.4. Referrals. Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of Health Plan, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted by the Provider Manual. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5. Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Health Plan to determine if an item or service is a Covered Service.

4.3.6. Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

4.4. Claims and Encounter Data / EDI.

4.4.1. Clean Claims. Providers shall electronically prepare and submit Clean Claims to Health Plan within _____ days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2. Additional Reports. If Health Plan requests additional information, data, or reports from a Provider regarding Covered Services provided to Members for risk adjustment data validation or other administrative purposes, even if Health Plan has paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.3. NPI Numbers / Taxonomy Codes. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.4. Electronic Transaction Requirements. Provider shall submit all claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in accordance with the current HIPAA Administrative Simplification transaction standards and WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.5. EFT / Remittance Advice. If a Provider is able to accept payments and remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice no later than 60 days following Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.6. Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same

items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.7. Subrogation. Providers shall cooperate and assist Health Plan with its subrogation efforts.

4.4.8. No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

4.5. Member Protections.

4.5.1. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons (other than Health Plan) acting on the Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3. Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4. Except where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

4.5.5. Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6. Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of

material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7. Quality Improvement. Providers shall comply with Health Plan's quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality or outcome measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members.

4.8. Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, and (d) corrective action plans.

4.9. Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.10. Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

4.10.1. Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.10.2. Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.10.3. Compliance Program / Reporting. OIG publishes compliance program guidance for health care firms available at http://oig.hhs.gov/fraud/complianceguidance.asp. Contracted Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and to report to Health Plan any suspected fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with

such requirements.

4.10.4. Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.10.5. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("**FQHCs**") or rural health clinics ("**RHCs**") where applicable.

(c) If a Governmental Authority imposes a reduction to the Federal or State funds Health Plan receives under a Government Contract, Health Plan may adjust its payments to Provider by an equivalent or comparable amount. Such adjustment shall be effective concurrent with the effective dates such reductions are imposed upon Health Plan.

4.10.6. Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.10.7. Compliance Audit. Health Plan shall be entitled to audit Providers with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.10.8. Fines / Penalties. The following applies if Provider is capitated or Health Plan has delegated activities to Provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of Health Plan by Governmental Authorities caused by Provider's failure to comply with Laws or Program Requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

4.11. Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement. As required by Program Requirements, Providers shall meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all accreditations necessary to meet such conditions of participation.

4.12. Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.13. Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public (**"Proprietary Information"**). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.14. Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall notify Health Plan within five business days of Contracted Provider's knowledge, or when Contracted Provider should have known, of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are suspended, limited, revoked or terminated, (g) a Provider is under investigation for fraud or a felony, or (h) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

5.1. ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2. Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines,

and state specific regulations (collectively, "Coding Authorities"). These software programs may result in claim edits for specific procedure code combinations.

5.3. Compensation. Compensation shall be as set forth in Attachment C. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement. Items and services constituting "**never events**" as described in the Provider Manual shall not be paid. Health Plan shall not pay for Non-Contracted Services.

5.4. Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5. Overpayments. Overpayment recovery shall be in accordance with Health Plan's Provider Manual and Providers shall refund Overpayments to Health Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Health Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Health Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud.

5.5.1 Unless prohibited by Laws or Program Requirements, Contracted Provider, for itself and the Providers, authorizes Health Plan to offset Overpayments against any future payments due to Provider.

5.5.2 Except for offsets related to changes in Member eligibility, which shall not require notice prior to deducting Overpayments, Health Plan shall notify Providers that an offset against future payments will occur unless the Provider (a) refunds such amounts within the Notice Period, or (b) provides Health Plan with a written explanation of why the Overpayments should not be refunded along with any supporting documentation. If the Provider does not respond within the Notice Period, Health Plan shall deduct Overpayments from future payments.

5.5.3 If Provider disputes Overpayments within the Notice Period, Health Plan shall review the Provider's explanation and supporting documentation. Health Plan shall notify Provider of its decision to either uphold or overturn its initial determination that the payment at issue was an Overpayment. If Health Plan upholds its decision, the Overpayment will be offset against future payments unless prohibited by Law or Program Requirements.

5.6. Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7. Health Plan Designees. With regard to administering Benefit Plans, Health Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to

the same extent Provider is required to cooperate with Health Plan.

6. Records, Access & Audits.

6.1. Maintenance. Contracted Provider shall, and shall cause its Providers and subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Members, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, "**Records**"). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable), and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider's obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2. Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider, Providers, and their subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause Providers and its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within [three][five] business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, collect, compile, and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan.

6.3. The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

7.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least [90] [Hospital: 180] days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2. Termination.

7.2.1. Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan, or Covered Service, at any time for any reason or no reason upon [90] [Hospital: 180] days prior notice to the other. Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon [90] [Hospital: 180] days prior notice to Contracted Provider.

7.2.2. Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other

Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3. Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of Members, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) another Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) Health Plan reasonably determines or a Governmental Authority determines or advises that a Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim, (f) a Provider fails to meet Credentialing Criteria, (g) a Provider fails to maintain insurance as required by this Agreement, (h) a Provider undergoes a change of control that is not acceptable to Health Plan, or (i) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

7.2.4. Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5. Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

8. Dispute Resolution.

8.1. Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking

any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2. Except as prohibited by State Laws, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3. Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a "**Dispute Initiation Notice**") to the other providing a brief description of the nature of the dispute, explaining the initiating Party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "**Dispute Reply**") to the initiating Party providing a brief description of the receiving Party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4. Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in _____, _____. The arbitration shall be conducted through the American Arbitration Association ("**AAA**") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than $10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1. Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of _____, except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to

be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in _____, _____, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.2. Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.3. Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.4. Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.5. No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

9.6. No Offshore Contracting. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

9.7. The following applies to State plans: Contracted Provider shall not, and shall require Providers and their subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its Providers and their subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.8. Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile, or (e) regular U.S. mail, first-class postage prepaid, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery, except for regular U.S. mail, which shall be deemed delivered seven days after the date of mailing. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.9. Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements, and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements, or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements, or accreditation standards, and such amendment shall be effective upon receipt.

9.10. Amendment. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.11. Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

9.12. Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term "**assign**" or "**assignment**" includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party.

9.13. Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan's or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.14. Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.15. Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member's benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.16. Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.17. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.18. Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.19. Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.20. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.21. Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.22. Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.23. Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.24. Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.25. Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

9.25.1. The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.25.2. The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.25.3. This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.25.4. The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

The following Attachments are incorporated into and made a part of this Agreement:
Attachment A - Provider Specific Requirements/Covered Services/Information
Attachment B - Program Attachments
Attachment C - Compensation

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

WellCare of Nebraska, Inc.	**Insert Name of Contracted Provider**
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____
	TIN: _____

Health Plan Notice Address:	Contracted Provider Notice Address:
Street Address City, ST Zip ATTN: Network Management	Street Address City, ST Zip ATTN:
Fax: Email:	Fax: Email:

FOR HEALTH PLAN USE ONLY

Effective Date: _____

(To be completed by Health Plan following approval of Contracted Provider as a Health Plan participating provider, which approval is subject to credentialing but not limited thereto. Any attempt by Contracted Provider to fill in an effective date shall have no force or effect.)

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

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ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(PHYSICIAN/IPA/PHYSICIAN GROUP/NP/FQHC/RHC/BEHAVIORAL HEALTH SERVICES)

1. Additional Definitions.

   a. "**Assigned Member**" means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member's Primary Care Provider.

   b. "**Covering Provider**" means a Provider who provides health care items and services to another Provider's patients when the other Provider is not available.

   c. "**Nurse Practitioner**" means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.

   d. "**Physician**" means a Provider who is a doctor of medicine or osteopathy.

   e. "**Primary Care Provider**" means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.

   f. "**Primary Care Services**" means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.

   g. "**Specialty Provider**" means a Provider who provides Specialty Services.

   h. "**Specialty Services**" means health care items and services within the scope of a particular medical specialty.

2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.

3. If Contracted Provider employs or subcontracts with Providers to provide Covered Services, Contracted Provider shall be responsible to ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.

4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

   a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.

   b. The Provider shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

5. If a Provider provides or arranges for the provision of Specialty Services, the Provider shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.

6. Except for Emergency Services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.

7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(MEDICAL FACILITY)

Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are facility based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

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ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(ANCILLARY PROVIDER)

Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are ancillary health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(HOSPITAL)

1. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are hospital based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

2. Covered Services include professional services of hospital based physicians and their physician extenders.

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ATTACHMENT A-2
INFORMATION FOR CONTRACTED PROVIDER / PRINCIPALS

1. Contracted Provider is a:

   _____ Sole Proprietor
   _____ Corporation
   _____ Partnership
   _____ Limited Liability Company
   _____ Professional Association

2. The Principals of Contracted Provider are:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

ATTACHMENT A-3
INFORMATION FOR PROVIDERS

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person

ATTACHMENT A-4
FORM OF OPT IN AGREEMENT
(SUBCONTRACTED PROVIDER)

THIS OPT IN AGREEMENT ("**Opt In Agreement**") is made by and between Health Plan and the subcontracted Provider identified below ("**Subcontractor**").

WHEREAS, Health Plan and [Name of Contracted Provider] ("**Contracted Provider**") are Parties to the Participating Provider Agreement (as now or hereafter amended, the "**PPA**"); and

WHEREAS, Subcontractor is a subcontracted Provider under the PPA and will receive substantial benefits from the PPA;

NOW, THEREFORE, in consideration of those benefits and Health Plan entering into the PPA and this Opt In Agreement, Subcontractor agrees to the following:

1. Subcontractor has reviewed the PPA. The PPA is made a part of and incorporated into this Opt In Agreement. Capitalized terms not defined in this Opt In Agreement have the same definition as given in the PPA.

2. Subcontractor agrees to the terms and conditions of the PPA. Wherever in the PPA an action is required to be taken by Contracted Provider or a Provider, Subcontractor agrees to perform such action. Wherever in the PPA any representation or warranty is made by Contracted Provider or a Provider, Subcontractor agrees to comply with such representation or warranty.

3. Any obligation of Subcontractor in this Opt In Agreement or the PPA shall apply to Subcontractor's Providers to the same extent that it applies to Subcontractor. Subcontractor shall maintain and enforce internal policies and procedures or written agreements with its employed Providers that are consistent with and require adherence to the terms and conditions of this Opt In Agreement and the PPA. Subcontractor has the authority to bind its subcontracted Providers to this Opt In Agreement and PPA, and shall require the timely and faithful performance of this Opt In Agreement and the PPA by its subcontracted Providers.

4. Subcontractor hereby grants to Contracted Provider a power of attorney, coupled with an interest, to represent and bind Subcontractor in connection with all matters related to the PPA and this Opt In Agreement including granting any waivers of any of the terms of the PPA and this Opt In Agreement, and entering into any amendments or modifications of the PPA or this Opt In Agreement.

5. Subcontractor shall not assign any of its rights or delegate any of its duties or obligations under this Opt In Agreement or the PPA, in whole or in part, without the prior written consent of Health Plan.

6. If the PPA is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then Subcontractor: (a) for at least six months, shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of the PPA and this Opt In Agreement, (b) shall accept compensation from Health Plan for such Covered Services at the fee for service rates set forth in the PPA for the applicable Benefit Plans or, if the PPA does not include fee for service rates, at 100 percent of Health Plan's then current fee for service rates for the applicable Benefit Plans, and (c) after six months, may terminate its continuing participation under the PPA and this Opt-In Agreement upon 90 days prior notice to Health Plan.

7. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the PPA or

this Opt In Agreement, shall Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall be construed for the benefit of Members, (b) does not prohibit collection of Member Expenses where lawfully permitted or required, and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontractor and Members or persons acting on their behalf.

8. This Opt In Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Nebraska, except where Federal law applies, without regard to principles of conflict of laws.

9. Any dispute with respect to this Opt In Agreement or the PPA or Subcontractor's performance under this Opt In Agreement or PPA shall be subject to and resolved in accordance with the dispute resolution procedures in the PPA.

10. Subcontractor warrants and represents the Providers listed on the attached schedule are included in and subject to this Opt In Agreement and Subcontractor has the power and legal authority to, and has taken all necessary corporate or other action to, authorize the execution and delivery of this Opt In Agreement and the performance of its obligations hereunder and in accordance with the PPA.

The undersigned Subcontractor, with the intent to be legally bound, hereby agrees and accepts the terms of this Opt In Agreement by signing below.

Insert Name of Subcontractor

By: _____

Print Name: _____

Title: _____

Date: _____

ATTACHMENT B
PROGRAM ATTACHMENTS

(See following attachments)

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ATTACHMENT B-1
NEBRASKA MEDICAID AND CHIP
PROGRAMS ATTACHMENT

1. Participation in Nebraska Contract. Subject to and in accordance with the terms of the Agreement, including this Attachment, Contracted Provider agrees to participate in Health Plan's provider networks and render Covered Services to Members pursuant to the Benefit Plan offered or administered by Health Plan for the Programs in accordance with the Nebraska Contract.

2. Compensation. Compensation for Covered Services provided to Members of Benefit Plans under the Nebraska Contract is set forth in Attachment C.

3. Additional Definitions. The following definitions shall be incorporated into the Agreement. Capitalized terms used and not otherwise defined in this Agreement shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the Nebraska Contract or under Nebraska law:

   a. "**Department**" means the Nebraska Department of Health and Human Services.

   b. "**Emergency Medical Condition**" means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

   c. "**Emergency Services**" means covered inpatient and outpatient services that are as follows: (i) furnished by a provider that is qualified to furnish these services under Title 42 CFR; or (ii) needed to evaluate or stabilize an Emergency Medical Condition.

   d. **"MLTC"** means the **M**edicaid and **L**ong-**T**erm **C**are division of the Nebraska Department of Health and Human Services.

   e. "**Medically Necessary**" or "**Medical Necessity**" means those Covered Services and supplies that are, under the terms and conditions of the Nebraska Contract, determined through Health Plan utilization management to be: (1)Necessary to meet the basic health needs of the Member; (2)Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; (3)Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research or health care coverage organizations or governmental agencies; (4) Consistent with the diagnosis of the condition; (5) Required for means other than the convenience of the Member, the Member's physician or other provider; and (6) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency; (7) Of demonstrated value; and (8) No more intensive level of Covered Services than can be safely provided.

   f. "**Member**" means an individual or Covered Person enrolled in a Benefit Plan issued by Health Plan pursuant to the Nebraska Contract.

g. **"Nebraska Contract"** or **"NE Contract"** means the Contract between the DHHS and Health Plan, and includes, without limitation, the collective documentation, exhibits, schedules, amendments, and addendums containing the terms, conditions and requirements to implement the Benefit Plan such as the General Terms, Special Terms (SOW) and Special Contract Attachments. The Nebraska Contract is a Government Contract as defined in the Agreement.

h. **"Nebraska Medicaid Program" (NE Medicaid or Medicaid)** means health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers. NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services.

i. **"Nebraska Medical Assistance Program"** means Nebraska Medicaid

j. **"Patient-centered medical home" (PCMH)** means a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.

k. **"Post-Stabilization Care Services"** means, in accordance with 42 C.F.R. § 438.114(a), Covered Services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's stabilized condition.

l. **"State"** means the state of Nebraska or its designated regulatory agencies.

m. **"Subcontractor"** means any organization or person who provides a function or service for the Health Plan specifically related to securing or fulfilling the Health Plan's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

n. **"Value-Based Contract"** means payment and contractual arrangements with providers that include two (2) components: (i) provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics and (ii) payment methodologies that align their financial and contractual incentives with those of the Health Plan through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

4. Cumulative Provisions. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers. Contracted Provider agrees to include the terms and conditions contained herein in its contracts with Providers. This Attachment may be updated as required by the Nebraska Contract, DHHS or other Governmental Authority.

5. Value-Based Contracts. Contracted Provider agrees that all applicable terms and conditions in the Nebraska Contract, any incorporated documents, and all applicable State and federal laws, as amended, including, without limitation 42 C.F.R. § 434.6, govern Contracted Provider's duties and responsibilities with regard to the provision of services to Members. **[NE Contract § IV.Q.6.c.]**

6. Emergency Services. Providers shall not be required to seek prior authorization for Emergency Services before the Member has been stabilized. Once a Member who receives Emergency Services is stabilized, the Provider shall seek prior authorization for Post-Stabilization Care Services for the Members specified in 42 CFR 438.114(e) and 42 CFR 422.113(c)(2). **[NE Contract § IV.E.14.b.]**

7. Covered Population. The covered population includes Health Plan's Members covered under the Nebraska Contract.

8. Unique Identifier. Providers who are physicians shall have a unique identifier in compliance with 42 USC § 1396u-2(d)(4).

9. NPI. All Providers that submit claims to Health Plan shall have a national provider identifier (NPI) number; this requirement shall be consistent with 45 C.F.R. § 162.410. The NPI number(s) must be the same NPI number(s) used for enrollment in the Nebraska Medicaid program. **[NE Contract § IV.S.4.h.]**

10. Cultural Competency. Providers are required to deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR 438.206(c)(2). **[NE Contract § IV.I.1.k.]**

11. American Indian Health Protections. In compliance with Section 5006(a) of the American Recovery and Reinvestment Act (ARRA) of 2009, any American Indian who is eligible to receive, is currently receiving or has ever received an item or service furnished by an American Indian health care provider or through referral is exempt from all copayments, cost sharing or similar charges. **[NE Contract § IV.F.1.b. (iii)]**

12. Mainstreaming of Members. To ensure mainstreaming of Nebraska Medicaid members, the Provider must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The Provider must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f): (i) denying or not providing a member any covered service or access to an available facility; (ii) providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary; (iii) subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and (iv) assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served. **[NE Contract § IV.I.3.a.]**

13. Deficit Reduction Act. In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), Contracted Provider shall, and shall require the other Providers to, comply with Health Plan's Fraud and Abuse Prevention Policy, as revised from time to time by Health Plan, and as otherwise may be required under the Nebraska Contract.

14. Compliance with Laws. The parties must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. **[NE Contract § IV.C.2.a.]**

15. Physician Incentive Plan Programs. The Parties shall comply with the requirements of the Physician Incentive Plan (PIP) regulations contained in 42 C.F.R. § 438.6(h), 42 C.F.R. §§ 422.208 and 422.210. No specific payment will be made directly or indirectly as an inducement to reduce or limit Medically Necessary services furnished to a Member. Contracted Provider shall provide any physician incentive plan information in an accurate and timely manner to Health Plan in the format requested by Health Plan. As applicable, Contracted Provider agrees to incorporate the requirements of the PIP regulations and this provision into its agreements with any persons/entities for the provision of services under this Agreement. **[42 C.F.R. 417.479, 422.208, 210] [NE Contract § IV.Q.7.]**

16. Maintenance of Records. Contracted Provider shall maintain an adequate medical record system which includes a complete medical record for each Member in accordance with State laws and regulations. In addition, Contracted Provider will maintain a medical records system which maintains inactive medical records. Contracted Provider must document all medical services that the Member receives in accordance with all applicable laws and consistent with utilization control requirements in 42 C.F.R. § 456. Contracted Provider must maintain Members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an accurate system for follow-up treatment. Contracted Provider will maintain methods and procedures that guarantee each Member the right to request and receive a copy of his or her medical records. Medical records must be legible, signed, dated and maintained in accordance will all applicable Laws. The Provider must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The Provider must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed. **[NE Contract § IV.R.13.]**

17. Response to Record Requests. Contracted Provider shall furnish duly authorized and identified agents or representatives of the State and federal governments, including but not limited to, the MLTC, the Secretary of the Department of Health and Human Services ("DHHS"), the DHHS Office of the Inspector General ("OIG"), or the Nebraska Medicaid Program Integrity Unit ("NMPI"), Medicaid Fraud and Patient Abuse Unit ("MFPAU")and Health Plan with such information as they may request regarding payments claimed for Medicaid services. The Contracted Provider must timely provide copies of the requested records within ten (10) business to the agency, the agency's designee (including Health Plan) or MFCU from the date of the request, unless the agency or MFCU sets, at its sole discretion, a period greater than 10 days. If such original documentation is not made available as requested, Contracted Provider, must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal office of Contracted Provider (or Contracted Provider's other locations, as applicable). Additionally, Contracted Provider agrees to grant the MLTC, DHHS, OIC, MFCU and/or Health Plan access during regular business hours to examine health service and financial records related to a health service

billed to the program. The MLTC will notify Health Plan no less than twenty-four (24) hours before obtaining access to a health service or financial record. **[42 C.F.R. 434.6, 438.6]**

18. Confidentiality of Member Records. Contracted Provider agrees in accordance with 42 C.F.R. § 438.224, that all Member medical records, as well as any other health information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in HIPAA, including confidentiality of family planning services. Contracted Provider further agrees to protect and maintain the confidentiality of mental health information and to release mental health information only as allowed and to release substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and federal law and regulations. Contracted Provider agrees to notify Health Plan within one (1) day upon discovery of a non-HIPAA –related breach.

19. Business Transaction Disclosures. Contracted Provider shall provide full disclosure of significant business transactions as set forth in 42 C.F.R. § 455.105. Contracted Provider shall submit, within thirty (30) calendar days of a request made by MLTC, federal DHHS or Health Plan, full and complete information about: (i) the ownership of any subcontractor with whom the Contracted Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (ii) any significant business transactions between the Contracted Provider and any wholly owned supplier, or between the Contracted Provider and any subcontractor, during the five (5) year period ending on the date of the request. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request within the time requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract. **[NE Contract § IV.T.3.]**

20. Ownership Disclosures. Contracted Provider shall make full disclosure of ownership, management and control information for the Contracted Provider, any subcontracting entities or Providers as required by 42 C.F.R. §§ 455.100 through 455.106. This information shall be delivered to Health Plan upon execution of this Agreement, and to Health Plan or MLTC within thirty (30) calendar days after any change in ownership. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request within the time requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract. **[NE Contract § IV.T.2.]**

21. Cost Sharing and Member Liability. Contracted Provider, and/or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the State to Health Plan or nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Contracted Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons, other than the Health Plan, acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with the terms of the agreement between Health Plan and Members. In compliance with 42 U.S.C. § 1396u-2(b)(6), Contracted Provider shall not bill Members for Covered Services any amount greater than would be owed in the entity provided the services directly (i.e., no balance billing by Providers). Contracted Provider, or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf. **[NE Contract § IV.C.16.]**

22. Continuation of Benefits. Continuation of benefits shall be in accordance with Nebraska laws and the Nebraska Contract. Upon the termination of the Agreement, except if the termination is for cause by Health Plan, Contracted Provider agrees to continue to provide care for non-pregnant Members who are undergoing a course of treatment for ninety (90) days, or if sooner, upon completion of the prescribed treatment plan. Contracted Provider agrees to continue to provide care to pregnant Members in their second or third trimester of pregnancy through postpartum care related to the child birth and delivery, which shall also include the post-partum visit. **[NE Contract § IV.S.17.c.]**

23. Provider Preventable Conditions. No payment will be made for provider-preventable conditions, as identified by the Nebraska Contract, or applicable federal or State law, as any may be amended. Contracted Provider agrees to comply with the reporting requirements of 42 C.F.R. § 447.26(d) as a condition of payment. **[42 C.F.R. 434.6] [NE Contract § IV.Q.12.]**

24. Coordination of Benefits. Contracted Provider must coordinate benefits in accordance with 42 CFR 433.135, et seq., and agrees not to pursue collection from the member but to identify third party liability coverage, including without limitation, Medicare and long-term care insurance as applicable, and except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004, seek such third party liability payment before submitting claims to Health Plan. **[NE Contract § IV.S.15.a.(v. and xi.)]**

25. Claim Submission. Contracted Provider shall submit Clean Claims, which do not involve a third party payer, promptly. Upon termination or expiration of the Agreement, Contracted Providers shall supply all information necessary for reimbursement of any outstanding medical claims. **[42 C.F.R. 434.6]**

26. Nondiscrimination. Health Plan will not discriminate for the participation, reimbursement or indemnification of Providers acting within the scope their license solely on the basis of that license or certification and will not discriminate against Providers who serve high-risk populations or specialize in conditions that require costly treatment. **[42 C.F.R. 438.12, 42 C.F.R. 438.214] [NE Contract § IV.I.2.b.]**

27. FQHCs/RHCs. If Contracted Provider is an FQHC or RHC, this Agreement provides for reimbursement for the FQHC/RHC at the Prospective Payment System (PPS) rate in effect on the date of service for each encounter in accordance with 471 NAC Chapters 29 and 34. **[NE Contract § IV.Q.9.**

28. Timely Access. Contracted Provider must meet the Nebraska Contract timely access to care and services standards. Contracted Provider must meet the hours of operation and appointment time requirements set forth in the Nebraska Contract and Health Plan's Provider Manual. Contracted Provider agrees to maintain hours of operation for Members no less than hours of operation offered to commercial enrollees or comparable to other Medicaid fee-for-service enrollees. Contracted Provider shall be available to Members twenty-four (24) hours a day, seven (7) days a week as required by the Nebraska Contract and Contracted Provider acknowledges that Health Plan shall implement corrective actions for Providers identified through the audit as failing to meet this standard. **[NE Contract § IV.I.1.g.]**

29. Newborn Enrollment Notification. If Contracted Provider is a hospital, Contracted Provider agrees to report births of Members to the Health Plan within 24 hours of the birth. **[NE Contract § IV.B.4.d.]**

30. Provider-Patient Relationship. Subject to the limitations described in 42 CFR 438.102(a)(2), Health Plan agrees that it will not prohibit or otherwise restrict Contracted Provider from advising or

advocating on behalf of a Member who isa patient of the Provider, regardless of whether benefits for such care or treatment are provided under the contracts, regarding: (i) the Member's health status; (ii) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (iii) any information the Member needs in order to decide among all relevant treatment options; (iv) the risks, benefits and consequences of treatment or non-treatment; or (v) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. **[NE Contract § IV.J.7.]**

31. Patient-Centered Medical Homes. Health Plan agrees to promote and facilitate the capacity of its provider to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Patients must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute and chronic needs of members, using best available evidence and appropriate technology. **[NE Contract § IV.I.7.]**

32. Excluded Persons. Contracted Provider agrees that it will not execute any agreement with an individual or entity that has been excluded from participation in the Medicare, Medicaid, and/or CHIP Programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with a State's Medicaid program or the Medicare program. Contracted Provider agrees to disclose the identity of any person excluded or who may be excluded to Health Plan immediately upon Contracted Provider's knowledge. Contracted Provider shall disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1). Health Plan must abide by any direction provided by the DHHS regarding whether or not to permit a Provider for participation in Health Plan's network. If any person who has ownership or control interest in Contracted Provider, or who is an agent or managing employee of Contracted Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XXI Services program, or if DHHS or Health Plan determines that Provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Health Plan shall not permit the Provider into the provider network.

33. Laboratory Services. If Contracted Provider is an entity that provides laboratory services, it agrees to comply with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 C.F.R. Part 493, Subpart A, as amended. Verification of CLIA licensure (including the CLIA Identification number) or Certificate of Waiver during the provider registration process is required. Payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings. **[NE Contract § IV.I.9.]**

34. Obligation to Suspend Payment to Providers. Health Plan, in compliance with 42 C.F.R. § 455.23 and the Nebraska Contract, shall suspend payments to a provider when there is credible allegation of fraud. NMPI will determine whether to suspend payments or if an exception is appropriate. Health Plan will comply with the applicable provisions of 42 C.F.R. § 455.23 and the Nebraska Contract when implementing this provision. **[NE Contract § IV.8.b.xvi]**

35. Termination of Providers. Health Plan shall comply with all requirements for provider disenrollment and termination as required by 42 C.F.R. § 455.416.

36. Enroll In State Medicaid Program. All Providers participating under this Agreement must first enroll with State Medicaid. **[NE Contract § IV.I.13.a.]**

37. Certification Regarding Lobbying. Contracted Provider certifies that no federal appropriated funds have been paid or will be paid on behalf of the Contracted Provider or any subcontractor or Provider to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the Nebraska Contract, grant loan, or cooperative agreement, Contracted Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. **[45 CFR § 3]**

38. Additional Requirements for Home and Community-Based Service (HCBS) Providers. If Contracted Provider and/or any Providers participate in Health Plan's HCBS Program ("HCBS Provider"), they shall ensure non-institutional Long Term Services and Support are provided in settings that comport with the CMS home and community-based setting requirements as defined in regulations at 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a). In accordance with 42 C.F.R. § 441.301(b)(1), Contracted Provider shall ensure that waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or IDF/ID.

ATTACHMENT C
COMPENSATION

(See following attachments)

DRAFT

ATTACHMENT C-[#]
NEBRASKA MEDICAID AND CHP COMPENSATION
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Nebraska Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses, if any:

[TO BE NEGOTIATED WITH PROVIDER]

3. Health Plan shall process claims and pay or deny a Clean Claim within the time period required by applicable Laws or the Nebraska Contract. The date of receipt is the date the Health Plan receives the Clean Claim as indicated by its data stamp on the claim. The date of payment is the date of the electronic funds transfer, check or other form of payment.

4. Health Plan may adjust claim payments due to coordination of benefits or subrogation.

5. Health Plan implements and prospectively applies Department's changes to its Nebraska Medicaid fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date the Department publishes the change on its website. Health Plan will not retrospectively apply rate changes to claims that have already been paid.

6. Health Plan may update code numbers or delete retired codes without notice or amendment to this Agreement as such are revised or implemented by the Department from time to time. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for items and services that are not included in the Department's payment system or fee schedule published on the its website.

7. The amount of compensation paid is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials. For example, a Provider who is a licensed clinical social worker (LCSW) will be paid at the rate for LCSWs, regardless of whether the LCSW has an advanced degree.

ATTACHMENT 5

3. Network Development Plan - Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.

Please see Network Development Plan attached herein.

WellCare
Health Plans

WellCare of Nebraska Network Development Plan

SECTION 1: GOALS AND STRATEGY OF NETWORK DEVELOPMENT

WellCare's extensive experience with the development of high-performing provider networks for government-sponsored healthcare programs provides us with the needed background and understanding of the specific health, geographic, cultural needs and preferences of the Nebraska Medicaid population that we will serve. Our network development and engagement strategy makes covered services available to the members of the Heritage Health program, through a committed network of primary care providers (PCPs), specialists, hospitals, Indian health services/tribal 638/urban Indian health (I/T/U) providers, urgent care facilities, federally qualified health centers (FQHCs), rural health clinics (RHCs), public health facilities, allied health care professionals, ancillary providers, behavioral health providers, and pharmacies.

The goal and approach of our network development strategy is to meet our members' needs by partnering with a diverse network of providers that represent a range of specialties and services and bring the most value to our members within each geographic region.

For over a year we have deployed WellCare leaders to meet with key stakeholders across Nebraska, laying the groundwork to prepare for network development in all areas of the state. We have met with hospitals, physicians, behavioral health specialists and social safety net providers. We have also focused on engaging with FQHCs, RHCs, and the state's medical, hospital, and health care associations because safety providers and the affiliations that currently exist are critical to building a comprehensive system of care to address Nebraska's needs. Our association meetings included meetings with Nebraska Hospital Association, Nebraska Medical Association, Leading Edge Nebraska, Nebraska Health Care Association, Nebraska Pharmacists Association, Health Care Association of Nebraska, Children and Family Coalition of Nebraska, Southeast Regional Provider Association ACO and tribal representatives. These efforts ensure that WellCare is prepared to fully execute our network development strategy to meet the state's expectations and do so by meeting the specific needs and challenges of local areas in Nebraska through the information gathered and relationships WellCare has built. WellCare is fully prepared to begin executing on our network development plan upon contract award.

As an example of our track record in building effective provider networks, upon being awarded a contract for Kentucky's Medicaid managed care program in late April 2011, we were required to build a fully accessible provider network in roughly ninety days in preparation for readiness review and a September 2011 implementation. Because WellCare had been actively engaged in building relationships with key providers and health systems for several months prior to being awarded the contract, as we have done in Nebraska, we were prepared to effectively execute on our network development strategy. Our success in launching a strong provider network in Kentucky contributed to supporting the state achieve its goal of implementing its program on schedule while ensuring that members received adequate access to services.

SECTION 2: Development of Network

WellCare of Nebraska understands the network requirements of the Heritage Health program contract. WellCare has combined the requirements with the expected membership and conducted geo-analytics to determine the network targets. In developing our networks we apply the necessary resources to actively recruit and maintain a network that offers our members a broad array of high-performing providers who deliver the scope of preventive, primary and specialty services, along with behavioral, pharmacy, and social services and supports. Our fundamental network development strategy is to:

- Determine expected enrollment
- Accurately determine precise network requirements to meet time, distance and appointment availability standards

- Target providers critical to meeting those standards and providing a comprehensive scope of services
- Expand our core network to encompass as many qualified participants as possible allowing both member choice and increased access to care

We employ a five-phase approach to network development and management, moving from early analysis of the market and membership needs to targeted recruitment, contracting, training and retention activities as described our network development and contracting continuum.

Our expected member enrollment is outlined in the table below.

Rating Region 1 (East)	Rating Region 2 (West)	Total
58,325	17,834	76,159

By segmenting the marketplace, adding the required time and distance standards and the required and essential providers, then layering the expected utilization, a targeted list of providers was created for our network. The targets are as follows:

- Providers currently providing physical, behavioral health and pharmacy services to Nebraska Medicaid members will be extended offers to contract
- Two largest hospital systems in Nebraska along with critical access hospitals, as described in Attachment 16
- Three largest provider groups collectively with over 1000 physicians, 150 large provider groups and small and individual providers throughout the state
- Independent urgent care centers
- FQHCs and RHCs throughout the state
- The complete Magellan behavioral health network
- Major behavior health facilities across the state
- Advanced practice nurses and physician assistants throughout the state
- Any willing pharmacy that accepts the terms and conditions of the contract
- All I/T/U providers
- WellCare national ancillary targets such as vision providers
- Providers in contiguous states to address specialty shortages and local referral patterns

Execution of the Strategy and Tactics

WellCare recruitment resources and tools will be located in the Nebraska marketplace. WellCare will deploy a large team of local resources to support face-to-face encounters with institutions, physicians and other providers. These resources will be supplemented by our national network development team which includes specialists in institutional, group practice, and ancillary contracting and legal experts in contract development. Our pharmacy benefit manager (PBM) also brings experienced staff to the network development process. Our network recruitment center will be staffed by a team of contract specialists who actively collect executed contracts, process mailings, answer inbound calls, make outbound follow up calls, gather and record required documentation, and assist providers with all aspects of contracting and credentialing.

We review and monitor daily and weekly target reports to determine the completion of the network and to identify necessary network adjustments.

WellCare Health Plans

Key Network Development Plan Activities & Milestones

WELLCARE OF NEBRASKA NETWORK DEVELOPMENT PLAN	
Month	**Goals and Tasks**
August 2015	➢ Research current delivery systems ➢ Identify key provider types for eligible populations ➢ Initiate relationships with key systems
November 2015	➢ Research patterns of care and current gap analysis; what populations are underserved and why? ➢ Build out relationships with key providers, professional societies and advocacy groups ➢ Initiate development of provider list based on specialty types and network access parameters
December 2015	➢ Develop Letter of Intent for interim use, if appropriate ➢ Conduct analysis of competitor networks and waiver provider network ➢ Analyze state fee-for-service file ➢ Obtain advocate feedback ➢ Review providers that have initiated a request to participate in the network ➢ Further develop provider list, identifying PCPs, behavioral health providers, specialists, FQHCs, RHCs, urgent care centers, laboratories, pharmacies, I/T/U providers, hospitals and other provider types for recruitment ➢ Preparation work on contract templates for PCP, specialty, ancillary and provider agreements ➢ Professional society visits, gather input from provider community on transformative partnerships. What has not worked and why
February 2016	➢ Provider Mailing #1: Distribute corporate overview to key health systems and provider groups ➢ Establish web and telephonic methods for provider questions and answers on network participation ➢ Develop network access strategies for rural/frontier/underserved areas. Examples might include telehealth, mobile delivery, clinic incentives, etc. ➢ Build out range of reimbursement options for fee for service, shared savings and value-based purchasing
March 2016	➢ Ancillary contract negotiation underway with national vendors (vision, 24/7 nurse line) ➢ Provider Mailing #2: Offer to contract letter to all providers on current list, including instructions on how to request a contract ➢ Create and secure approval for a workflow flyer to accompany all provider contracts, demonstrating the steps for provider credentialing and configuration ➢ Create email inbox for provider contract requests and/or questions and answers, establish frequently asked question workflow and publication method
April 2016	Initiate negotiations/redlines with key hospitals, facilities, IPAs and complex providers Inventory management established for incoming provider contracts, including data integrity audit Provider Mailing #3: Filter mailing list against in-house inventory, then drop PCP/specialist contracts via USPS Round One: Regional Provider Information Summits –Informational and open question and answer (Q&A) forums for all Nebraska and border-state providers
May 2016	➢ Post Nebraska Provider Q&A link on WellCare of Nebraska home page ➢ Filter mailing list against in-house inventory, then drop PCP/specialist contracts via USPS

	➢ Ground game: Initiate outbound call campaign to schedule network development visits and promote Q&A interface ➢ Round Two: Regional Provider Information Summits – Informational and open Q&A forums for all Nebraska and border-state providers
June 2016	➢ M-W-F Checkpoints: Weekly gap analysis review each Monday morning, with Wednesday p.m. and Friday p.m. progress reports ➢ All inbound contracts and credentialing applications audited for complete information (signatures, W9, etc.) before provider load form (PLF) created ➢ PLF exceptions for missing/inaccurate information under a 72-hour turnaround. Flat file load template disseminated as appropriate ➢ County-by-county blitz visits to non-respondents, daily debrief and determination of barriers and remediation strategies
September 2016	➢ Access-compliant network contracts in house and in credentialing/configuration workflow for directory production and January 1, 2017 implementation. ➢ Submit our provider network to MLTC at least 90 calendar days prior to contract start date.
October 2016	➢ Submit documentation to MLTC 45 days prior to implementation on any services or provider types that do not meet MLTC standards due to lack of providers in the area.

In developing our network we will

- Offer female members direct access to a woman's health specialist for routine and preventive care
- Offer direct access to specialists in special situations including members who meet special health care needs criteria
- Ensure a provider network that includes sufficient numbers of providers with experience and expertise in:
  - Co-occurring mental health and substance use disorders/developmental disabilities
  - Serious and persistent mental illness
  - Severe emotional disturbance among children and adolescents
  - Sex-offending behaviors, eating disorders, co-occurring serious mental illness, and common chronic physical illness
- Contract with providers who demonstrate a commitment to the behavioral health principles of care defined in the Request for Proposal (RFP) Section IV.L, Care Management, including rehabilitation and recovery and focus on recovery-oriented, trauma informed services and trauma-specific treatment programs
- Cooperate with the Department of Health and Human Services Division of Behavioral Health and state behavioral health regions as we establish our network

SECTION 3: Ongoing Network Management – Including network adequacy, identifying and resolving barriers and network gaps

Once the initial network is completed, assessing the adequacy of our provider network is a continuous process. The staff uses numerous tools and data sets to identify potential gaps and the need for expansion activities. Our ongoing activities allow us to identify opportunities as they arise to proactively respond with enhancement strategies. A key element to our overall Network Development Plan is the ongoing management and assessment of our network of providers at a regional and county level.

The comprehensive, ongoing monitoring and development of our provider network allows us to maintain and work to exceed member satisfaction, access to care and to comply with the Heritage Health program requirements. Analysis includes:

- **GeoAccess Reports:** On a monthly basis, these reports evaluate that time and distance standards are

being adequately met at the provider level to meet the needs of members in each county. GeoAccess results are the key element reviewed at a quarterly meeting and an actionable plan results from the analysis.

- **Quality Dashboard:** On a monthly basis, we measure HEDIS results at the provider or group level. Quality trends and care gap quality improvement data is shared with providers during regularly scheduled meetings with providers, our field quality team and our provider services specialists.
- **Provider Efficiency:** On a monthly basis, we will review member cost of care with our key provider groups to identify providers with utilization levels that are outside of a normal range of bell curve utilization. We also review key statistics at a provider level, including their use of electronic funds transfer and electronic data interchange for administrative efficiency.
- **Appointment Availability:** When recruiting providers for our network, we validate that they have capacity and are able to make appointment times available to members on a timely basis. We engage a third-party vendor to conduct an annual study of appointment availability using a statistically valid sample of PCP and specialist practices. Average appointment times are evaluated to ensure that offices are in compliance with the access standards as defined in the contract.
- **Out Of Network Monitoring:** On a monthly basis, out-of-network utilization reports are reviewed by health services and the network teams.
- **Open/Closed Panels:** Primary care closed panels are measured and reported to provider services.

Our network development standards are detailed in the table below.

WELLCARE NEBRASKA NETWORK DEVELOPMENT APPOINTMENT AVAILABILITY ACCESS STANDARDS	
Provider Type	**Standard**
Emergency Services	Available immediately upon presentation 24/7. Emergent behavioral health needs referred within one hour or two hours in designated rural areas
Urgent care	Same day by PCP or as arranged by MCO
Non-urgent, sick care	Within 72 hours or sooner if the member's medical condition deteriorates
Family planning	Within 7 calendar days
Non-urgent, preventive	Within 4 weeks
PCPs	1 physician practice, office hours of at least 20 hours a week 2 or more physician practice, office hours of at least 30 hours a week
High volume specialists*	Routine: 30 calendar days of referral
Other specialists	Consultation available within 1 month of referral or as clinically indicated
Laboratory and x-ray	Routine: 3 weeks Urgent: 48 hours (or as clinically indicated)
Maternity care	1st trimester: 14 calendar days; 2nd trimester: 7 calendar days; 3rd trimester: 3 calendar days; High-risk: 3 calendar days of identification
WELLCARE NEBRASKA NETWORK DEVELOPMENT GEOGRAPHIC ACCESS STANDARDS	
Provider Type	**Standard**
PCPs	2 PCPs in 30 miles urban; 1 PCP in 45 miles rural; 1 PCP in 60 miles frontier PCPs include: - Physicians specializing in general practice, family practice, internal medicine, pediatrics

	or obstetrics/gynecology (OB/GYN) ➢ Advanced practice nurses and physician assistants when practicing within the scope and requirements of their license
Behavioral health inpatient and residential	Rural and frontier: Sufficient locations to allow members to travel and return home within a single day or alternative plans for accessing comparable levels of care if no inpatient available within that standard
Behavioral health outpatient	Urban: Adequate choice with 30 miles Rural: Minimum of 2 providers within 45 miles Frontier: Minimum of 2 providers within 60 miles Rural and Frontier: Use of telehealth if no providers in county
High volume specialists*	1 provider within 90 miles
FQHCs and RHCs	Contract with all FQHCs and RHCs in Nebraska Notify MLTC if contract cannot be reached
Urgent care centers	Good faith effort to contract with urgent care centers in Nebraska Maximize availability of urgent care services to members Maintain documentation detailing the efforts
Pharmacists	Urban: 1 retail pharmacy within 5 miles of 90% of members Rural: 1 retail pharmacy within 15 miles of 70% of members Frontier: 1 retail pharmacy within 60 miles of 70% of members
Hospitals	Contract with a sufficient number of hospitals to ensure that transport time will not exceed 30 minutes, except in rural areas where access time may be greater Critical access hospitals as defined by Attachment 16, other Nebraska and contiguous hospitals
Indian Health Services/Tribal 638/Urban Indian Health	Extend contracts to all Sufficient number to ensure timely access to services for American Indian members
Contiguous states	Extend contracts to providers in contiguous states to address local referral patterns

*Includes cardiology, neurology, hematology/oncology, OB/GYNs and orthopedics specialties

In the event that we discover that there are gaps in the network or barriers to care that require network remediation, WellCare of Nebraska employs the following solutions:

- **Leverage Provider Partnerships:** Our network development team and provider services teams encourage partner network providers to extend hours and reach to expand access during initial contracting and ongoing conversations with the network.
- **Closed Panel Management:** The providers identified with closed panels are specifically contacted by provider services to determine if they are closed panel because their practice is at full capacity and are closed to all payers, or if there is an issue with WellCare that can be resolved.
- **Telehealth:** WellCare will partner with providers, groups of providers, and the Nebraska Statewide Telehealth Network (NSTN) to extend health care resources to those in need using video technology. NSTN is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, provider offices and rural health clinics. This includes clinical consultation, support groups, education and training and connectivity for administrative meetings among professionals.
- **Transportation:** Recognizing transportation as one of the biggest barriers to health care in Nebraska, we will facilitate coordination of transportation for members to improve access to care. We will use warm transfers and assist members in making appointments with the transportation vendor. In

addition, we track all referrals to non-benefited services including transportation.

- **Out-of-Network Utilization:** As needed, we will develop relationships with non-participating providers to allow us to work with them on a case-by-case basis to secure member access to the appropriate level of medically necessary care. Typically, we arrange care with out of network providers by executing single case agreements that authorize care for a specific member. In limited instances we will seek to establish a permanent non-participating agreement with high-impact providers who do not wish to contract. We will always seek to contract with any high-quality provider that has out of network utilization.

SECTION 4: Provider Training & Support

Initial and ongoing provider training and support is foundational to our network development and management plan, as well as provider retention. WellCare's provider services staff delivers training and answers provider questions related to training content. We employ a blended training delivery model that includes classroom, provider's office, web courses, & real-time interactive web meetings. The following provider training modules support compliance, improve provider performance and quality, and enhance provider satisfaction.

- How to register with our Provider Portal
- How to Request an Authorization
- How to File a Claim
- How to submit a corrected claim
- How to Submit Encounters when a service is rendered that is not tied to payment
- Understanding Explanation of Payments Documents and Files, using the Provider Portal
- Electronic Funds Transfer (EFT) and Electronic Remittance Advices for Claims Payments
- How to File an Appeal if a claim is denied , focusing on the process and timeframes
- Member Enrollment and Eligibility Verification
- Member Engagement Strategies
- Completing Health Risk Assessment and Comprehensive Assessments
- Benefits Overview
- Cultural /Linguistic/Social Needs of Members/Cultural Competency
- Heritage Health Program and Contract requirements
- EPSDT Requirements and Processes
- Identification & Reporting of Abuse, Neglect, and Exploitation of Children & Vulnerable Adults
- Education on Care Management/Disease Management/Wellness programs
- Utilization Management Criteria
- Complaints and Grievances
- Pharmacy Processes and Resources
- Health Information Exchange (HIE)/Electronic Health Record (EHR)
- HEDIS & Other Quality Goals & Tools
- Coding/Medical Records

ATTACHMENT 5

4. Key Staff Resume's - As possible, submit resumes of proposed key staff as described in Section IV.X - Transition and Implementation.

Please see resumes attached herein of the key staff members WellCare is committing to have in place to participate in the transition coordination/collaboration process as described in Section IV.X. These positions include the following:

- Chief Executive Officer: Lauralie M. Rubel
- Chief Operating Officer: William Keena
- Medical Director/Chief Medical Officer: Dr. James Howatt
- Behavioral Health Clinical Director: Dr. Michael Orlosky
- Member Services Manager: Paul Hineman
- Provider Services Manager: Drew Hobby
- Information Management and Systems Director: Robert Klopotek
- Quality Management Coordinator: Dr. Richard Petrucci
- Case Management Administrator: Marcia Lelis Welch

LAURALIE M. RUBEL

Career History

WellCare Health Plans, Inc. Tampa, FL

State Plan President (August 2015 to Present)

- Plan leader for WellCare's Medicaid expansion into Iowa, inclusive of member-centered strategy, operational implementation, infrastructure and plan performance.

Vice President, Market Development (February 2015 to August 2015)

- Leads business expansion and new market growth through effective planning, collaboration and efficient stewardship.

Vice President, Business Training (September 2013 – February 2015)

- Executive leadership and accountability for associate training in Operations, Sales, Health Services and Network Management/Provider Relations.

Vice President, Market Initiatives (January 2013 – September 2013)

- Acquisition integration and business development.
- Network and communications liaison between seller, acquired entity and WellCare.
- Onboarding support to new associates.
- Business process assessment and improvement.

Vice President, Provider Strategy (July 2011 – January 2013)

- Development and execution of provider strategy in South Carolina, Kentucky, Louisiana, Georgia and Texas to encompass quality improvement, member and provider satisfaction, new business development, and expansion/re-procurement network strategy.

Market Chief Operating Officer (July 2009 – June 2010)

- Promotion to Market COO over Atlanta and North Georgia, inclusive of P&L management of 325,000 covered Medicaid lives in 53 counties.

Senior Market Director (May 2008 – July 2009)

- Promotion to full P&L responsibility for Atlanta Medicaid and Medicare business segments.
- Responsible for medical cost reduction strategy development and implementation.
- Network development, provider relations and compliance.

- SG&A control and policy development for contracting, quality and health improvement initiatives.

UHS – Pruitt Corporation, Atlanta, GA

Vice President of Care Management (October 2010 – July 2011)

- Executive leadership of centralized care management, including intake, concurrent review and continuum of care for more than 125 hospice, home health, skilled nursing and post-acute care facilities and offices across the Southeastern U.S.
- Negotiation and management of payer agreements and relationships, inclusive of billing integration and internal/external payer education.

Regional Director, Payer Relations (June 2010 – October 2010)

Humana, Atlanta, GA

Director of Market Operations, Southeast (January 2005 – December 2005)

Covenant Health – Cariten Senior Health and PHP TennCare

Director of Government Programs (2003 - 2004)

Director of Medicare (2001 - 2004)

Provider Relations Manager (1998 – 2001)

Academic Background

University of Tennessee at Knoxville & Tusculum College
- Bachelor of Science in Organizational Management

References

Dora Wilson, COO, Molina Healthcare of South Carolina
- Phone: 843-740-1780
- Address: 4105 Faber Place; North Charleston, SC 26405

Patrick Devlin, VP of Talent, Evolent Health
- Phone: 571-385-3889
- Address: 800 North Glebe Road, Suite 500; Arlington, VA 22203

Courtney Pearre, VP, Government Relations, Amerigroup Tennessee
- Phone: 615-717-7990
- Address: 22 Century Boulevard, Suite 310; Nashville, TN 37214

WILLIAM KEENA

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Integrated Solutions (September 2015 – Present)

- Executive leader accountable for oversight and execution of acquisition integration activities. Serves as a trusted resource in business planning, organizational planning, financial performance and initiatives related to integration activities. Role may provide interim executive leadership for new growth or acquired businesses until permanent leadership is established.

Acclaris, Tampa, FL

Chief Operating Officer (July 2013 – June 2015)

- Led the transformation of the company operations that prepared the company for a strategic acquisition at triple the company's prior value which occurred in May of 2015.
- Stabilized and improved company operations enabling scalability, client growth and transformation to a consumerism model.
- Improved turnaround times of processes such as customer inquiry tickets by more than 30%. Increased overall corporate productivity by 34% by reducing costs and improving quality (To over 99.5% Financial).
- Increased Client loyalty (Net Promoter Score) from -48 to +3.2 during this time. Led company Operations and Information Technology areas across all six US and India locations. Responsible for service and relationships with all clients including Bank of America, Fidelity Investments, Xerox and Highmark Blue Cross/Blue Shield. Led the redesign and replacement of the data center hardware and network, from data storage to the fax servers. Personally oversaw each phase of the project and migration to the new infrastructure.
- P & L responsibility on 10% of the corporate revenue in the business process outsourcing line of business, personally sold $520,000 in new business (23% growth) in 2014 with excellent (>50%) margins.

VALA Consulting/CACI

Independent Consultant (July 2008 – June 2013)

- Created and operated an independent consulting business. The largest opportunity was at CACI, a contractor to the US military. While at CACI ran a key program and grew it from 4.18 million in annual revenue to over 17 million.
- Led multiple software development teams across six sites with 155 direct reports. Projects included creating a ground up next generation supply/logistics system for the US Navy and Marines (Single Supply Baseline) using open source tools.

- Functional lead and Subject Matter Expert on a suite of projects to upgrade the systems and processes at a California based Medicaid/Medicare Health plan.

AMERIGROUP Corporation Virginia Beach, VA

Executive Vice President, Support Operations (May 2006 – June 2008)

- Spearheaded the turnaround of Operations to ensure that significant compliance and encounter submission issues were addressed while simultaneously managing significant growth (700,000 new members) and a system conversion.
- Reduced IBNR (Incurred but not reserved) exposure by 99.9% for prior periods.
- Eliminated backlog and restored DOI (Department of Insurance) compliance in key states such as Texas. These efforts increased the stock price from $17 to $34 in less than two years. Led the claims, encounters, front end operations, credentialing, contract configuration and three National Service Centers (Virginia, Florida and Tennessee), plus the Clinical Call Center (Provider services area), and other Operations departments.
- Budget of over 100M, 1500+ associates.
- Member of the Executive Team.

Academic Background

University of Connecticut
- Bachelor of Arts, Magna Cum Laude

References

Tony Pino, Senior Vice President
- Phone: 443-769-7609
- Address: 300 E. Lombard St., #1610; Baltimore, MD 21202

Bebe Agnew - Bezzeg, Senior Director, Coventry Workers Comp Services
- Phone: 813-421-8575
- Address: 5130 Eisenhower Blvd S. #3; Tampa, FL 33634

Donald Fowler, Vice President, HighMark
- Phone: 412-544-1531
- Address: P.O. Box 226; Pittsburgh, PA 15222

JAMES HOWATT, MD, MBA

Career History

WellCare Health Plans, Inc. Tampa, FL

Medical Director (October 2015 - Present)

- Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations.
- Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease management activities, quality improvement activities, and provider relations functions.

Heritage Provider Network, Inc. Los Angeles, CA

Private Consulting (June 2014 – October 2015)

- Assigned to dual eligible demonstration implementation, CMO Cumberland Health Analytics, Guidepoint Global advisors and Pharmacy advisory boards.

WellPoint/Anthem/CareMore/Amerigroup Indianapolis, IN

Staff Vice President, Medical Director (2011 – 2014)

- Assigned to the Corporate Duals Team, responsible for winning and implementing Duals Demonstration projects. Participated in winning presentations to CA, VA and NY.

Senior Medical Officer (2012 – 2013)

- Dedicated to developing and implementing the Model of Care for CareMore participation in Dual Eligible Demonstrations.

Staff Vice President State Sponsored Business (Medicaid) Care Management (2011 – 2012)

- Responsible for oversight and management of Medical Directors and collaborative structure and management of over 1.8 million Medicaid beneficiaries in 10 states. Duties include Utilization Management, Quality Management and clinical input into member and provider management strategies.

Molina Healthcare Long Beach, CA

Chief Medical Officer Medicaid Services (2010 – 2011)

- Designed and promoted innovative products expanding the role of MMIS and Fiscal Agent services for state Medicaid programs.

Executive Vice President, Corporate Chief Medical Officer (2007 – 2010)

- Responsible for representing Medical Affairs in cross-functional committees driving strategy for national contracting and network management. Oversight responsibility for risk adjustment score strategies.

Chief Medical Officer (2006 – 2007)

- Helped organize integrated healthcare model which won national recognition (Washington Medicaid Integration Partnership).

Academic Background

University of California, San Francisco
- Doctorate Degree

University of Phoenix
- Master's Degree, MBA

References

Thomas Wilfong, Anthem
- Phone: 757-490-6900
- Address: 4425 Corporation Lane, Suite 100; Virginia Beach, VA 23462

Michael Siegel, MD, Molina Healthcare
- Phone: 562-435-3666
- Address: 1 Golden Shore, Long Beach; CA 90802

Mark Kiffer, DO, Humana
- Phone: 480-515-6400
- Address: 20860 N Tatum Blvd, Suite 400; Phoenix, AZ 85050

MICHAEL J. ORLOSKY, M.D., M.M.M., C.P.E.

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Behavioral Health (2014 to Present)

- Responsible for all WellCare markets for the performance of Behavioral Health operations including medical expense, quality, and provider management.
- Developed curriculum for Integrated Care Management training.
- Provided direction and design for on-boarding training for all clinical staff for WellCare.
- Developed Behavioral Health model of care for the enterprise.

Senior Medical Director, Florida Market (2013 - 2014)

- Assisted with the Managed Medical Assistance Intent to Negotiate presentations to AHCA, with WellCare winning 8 of 11 Florida regions.
- Created clinical model and program strategy for Patient-Centered Medical Homes.
- Facilitated the development of a Behavioral Health PCMH with Lakeside and a shared savings pharmacy program.
- Established relationships with key provider groups and facilities.

Health New England

Medical Director (2011 - 2013)

- Responsible for the medical and case management activities related to managed medical operations for Commercial, Medicaid, and Medicare lines of business.
- Served as Medical Director for HNE's Medicare Advantage line of business, which was awarded 5 STAR status by CMS in 2012 and 2013.
- HNE's Commercial HMO ranked 11th Nationally by NCQA.
- HNE's Medicare Advantage program ranked 26th Nationally by NCQA.
- Responsible for implementing Risk Adjustment program for HNE's Medicare Advantage Beneficiaries.
- Assisted with CMS Best Practice Review with HNE Management.
- Speaker at various Medicare Advantage conferences related to achieving 5 STAR status.
- Developed and implemented Patient-Centered Medical Homes.
- Developed and implemented Bundled Payment programs for orthopedic procedures.
- Served on the Board of Directors for Massachusetts Health Quality Partners.
- Headed the Medical Technology Assessment Committee (MTAC) for HNE.
- Interface with physician providers to create new systems of health care delivery (ACO and Full Risk PCMHs).

ValueOptions North Carolina Service Center

Interim Medical Director (2010 - 2011)

- Served as interim medical director for North Carolina office performing utilization review activities and supervision of clinical staff.

Human Capital Specialists

Executive Vice President and Chief Operating Officer (2009 - 2010)

- Responsible for the development and implementation of consulting services for Human Capital Specialists with focus on health care opportunities that offer:
  - Improved quality and operational results
  - Six sigma strategies for process improvements
  - Financial turnaround
  - Change management
  - Expert training, information, and implementation skills
- Led the integration of 8,000,000 behavioral health covered lives for a large, multi-state Blue Cross Blue Shield Health Plan.

WellPoint, Inc., North Haven, CT

East Regional Vice President of Behavioral Operations (2006 - 2009)
Executive Medical Director, Northeast Division (2003 – 2006)

- Drove the operational performance of the 7th, 16th, and 20th nationally ranked Health Plans as published in US News and World Report (2008).
- Led the expansion of Behavioral Health Operations from a single state (CT) and 23 staff, to a regional operation with 7.6 million enrollees in Connecticut, Maine, New Hampshire, New York, Virginia, and Georgia.
- Managed and led the reorganization of 160 Associates in three offices (Atlanta, Richmond, and North Haven), with an annual operating budget of over $95 million and revenue of $600 million.
- Delivered operating gain that exceeded budget every year.
- Improved associate engagement and manager effectiveness measures to Best in Class levels.
- Succeeded at full accreditation from URAC and NCQA and created a HEDIS improvement strategy that was published in a national quality journal.

Clinical Experience

Medical Director, 5SB Unit, Mercy F. Hospital, Darby, PA (1998 – 1999)

- Lead several multidisciplinary teams to re-engineer the treatment process of seriously mentally ill patients in an intensive, managed-care environment.
- Established and monitored quality outcomes through the institution of control charts and data measurements.

- Developed programs with Delaware County Mental Health to address the displacement of psychiatric patients due to the closing of Haverford State Hospital.

Director, Apogee, Inc., King of Prussia, PA (1996 – 1998)

- Served as Director of Comprehensive Mental Health Services. Member of Northeast Regional Directors. Served on Apogee's National Committee of Clinical Quality. Responsible for Budgeting and Strategic Planning. Redesigned the Performance Appraisal System for Clinicians in 112 Clinics.

Academic Background

Tulane University's School of Public Health and Tropical Medicine, New Orleans, LA (1998 – 1999)

- M.M.M, Master's Degree in Medical Management

The Waltham Hospital (PGY-1), and Massachusetts General Hospital (PGY-2 through PGY-4), Boston, MA M.M.M, Master's Degree in Medical Management (1978 – 1982)

- Psychiatric Residency

College of Medicine, University of South Florida, Tampa, FL (1975 – 1978)

- Doctor of Medicine (M.D.)

The John's Hopkins University, Baltimore Maryland (1972 – 1975)

- Bachelor of Arts

References

Dr. Steven Korn, Anthem BC/BS

- Phone: 203-677-8069
- Address: 108 Leigus Road; Wallingford, CT 06492

Dr. Seth Feuerstein

- Phone: 203-623-7714
- Address: 657 Orange Center Road; Orange CT 06477

Dr. Donna O'Shea

- Phone: 413-794-7045
- Address: Chestnut Street; Springfield MA 01199

PAUL HINEMAN

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Channel Communication Services (2015 to Present)

- Provide strategic direction, policy, operational planning and execution across all internal/external Customer Service operations. Provide strategic direction, consistency and oversight for member and provider channel communications, including establishing/maintaining positive relations between the Company and its key constituents to advance business objectives.
- Leads teams responsible for collaborating with business partners and executive leadership to drive and enhance the company's business objectives through strategic, compliance-based and transactional communications initiatives across a variety of communications channels.
- Leads the development and implementation of channel communications-related policies and process improvements for realized cost savings and overall volume efficiencies,
- Strategizes, leads and coordinates vendor procurement; manages vendor relationships in relation to maintaining service level agreements for member/provider communication/processing functions.

Nielsen, Oldsmar, FL

Vice President, Florida Operations Leader (2011)

Senior Vice President, US Call Center Operations (2012 – 2015)

- Accountable for the strategic direction of four US based Market Research call centers and two third party vendors internationally consisting of 2,200 part time and full time associates supporting Operations, Training, Quality and Work Force Management departments. Leveraged predictive dialers to initiate over 100MM dials and completed over 6MM surveys and recruitment calls annually.
- Led initial integration for 1.3B Arbitron acquisition representing the Data Acquisition department which consisted of both field and call centers totaling 1,000 impacted employees. Process required consistent collaboration with key business owners and stakeholders including frequent engagement with the COO.
- Integrated six Call Centers and three Lines of Business due to a large acquisition late 2013
- Budgetary savings as a result of the integrations and subsequent consolidation in excess of 15% or 8MM through first 18 months primary through site consolidation and labor efficiencies.
- Led integration efforts on new CATI and Dialer solutions for improved quality and efficiency through improvements in contacts, dialing efficiency and agent usability.

WellCare Health Plans, Inc., Tampa, FL

Vice President, Customer Service Operations (2009 – 2011)

- Provided the strategic direction of internal and external customer service groups that supported multiple products under the Medicare and Medicaid lines of business. Ensured Training, Quality, Productivity, and Compliance standards were met through effective communication, training, and planning.
- Led Customer Service process improvement initiatives focused on new member enrollment and intake activities.
- Drove efforts to enhance the Member's experience at our two Philippines sites through improved on line help tools, training enhancements and use of analytics from 3rd party quality vendor.
- Provided direction to consolidate site locations for Medicare product lines with increased concentration at near shore site in the Dominican Republic with savings of 20%+ for this LOB.
- Coordinated the launch of the customer service function for the newest market, Hawaii.

Senior Director, Customer Service Operations (2008 – 2009)

- Provided strategic direction of external customer service groups that supports multiple product lines under the Medicare line of business.
- Led efforts to enhance and promote usage of an external website for self-service functionality for both Providers and Members with increases over 150% in under 12 months.
- Established process improvement initiatives for call center functions derived from analysis on first call resolution and a third party customer satisfaction survey process.
- Provided support to launch two vendors sites in the Philippines in efforts to reduce costs by as much as 40% for two Medicare product lines.
- Contracted with 3rd party Quality vendor to provide independent quality review to provide analytics on compliance and quality standards.
- Achieved recertification for call center excellence from JD Power in 2008.

Director, Customer Service (2005 – 2008)

- Led the coordination and set up of the customer service function for the new national Medicare Part D product, Prescription Drug Plan, responsible for generating over one billion in revenue by 2008. Successfully managed the launch of five call centers to support this product in under 90 days.
- Established vendor contracts, telecom and IT set up, product training, policies and procedures, and support team for call centers in less than 90 days.
- Achieved 15% reduction in 25MM call center budget over the first 8 months of 2006.
- Improved productivity in the call centers through the implementation of a new User Interface for the call center staff that reduced Average Handle Time by 32% over seven months.
- Implemented a post-call satisfaction survey and maintained 82%+ satisfaction rates since launch of the product.
- Managed numerous on-going and proactive outbound call campaigns to improve customer satisfaction and retention.
- Provided strategic direction and oversight for the customer service function for both Medicare and Medicaid product lines within an internal and outsourced environment.
- Achieved JD Power certification for call center excellence in 2007.

Academic Background

Palm Beach Atlantic University

- Bachelor of Science, Business Administration

References

John Eagle, President, Internal Audit – FIS

- Phone: 727-227-5129
- Address: 11601 Roosevelt Blvd; St. Petersburg, FL 33716

Tamela Puckett, Senior Human Resources Business Partner, Nielsen

- Phone: 813-366-3012
- Address: 501 Brooker Creek Blvd; Oldsmar, FL 34677

John Streitmatter, Director, Leadership Research Institute

- Phone: 813-785-2633
- Address: 499 Cove Drive; Palm Harbor, FL 34685

DREW HOBBY

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Business Development (April 2015 – Present)

Vice President, Field Network Management (March 2014 – April 2015)

- Lead organization responsible for hospital contracting, physician contracting, risk provider contracting, provider relations, behavioral health and provider solutions across the state of Florida.
- Responsible for development and execution of organization's network contracting and management strategy.
- Partner with internal resources to analyze cost data, medical trends, and quality results to deliver network that meets strategic priorities of market.
- Provide strategic negotiation assistance to team specifically around rate evaluation and contractual language. Constantly monitor regulatory landscape, proactively evaluate contractual feasibility, and partner with other departments (legal, government affairs, configuration, finance, and legal) to ensure ability to implement accordingly.

Senior Director, Product Operations – Florida Healthy Kids (January 2012 – March 2014)

- Responsible for P&L ownership of WellCare's Florida Healthy Kids (SCHIP) product.
- Led the program design, RFP response, and negotiations of statewide RFP.
- Obtained largest award and successfully expanded county footprint from 18 to 65 (out of 67) counties.
- Expanded top line revenue by over 30% in year one.
- Led the successful implementation of a large scale roll-out across 48 counties with varying degrees of experience with managed care.
- Led WellCare of Florida's Exchange offering including network build and other strategic product offering components.

Senior Director, Medicaid Expansion (April 2011 – January 2012)

- Identified, pursued, and won new Medicaid business for the organization
- Worked with existing market leaders or business development team to understand local regulator's Medicaid program needs, design WellCare's response, and help lead response to RFI/RFP requests

KPMG, LLP

Senior Manager/Director, Advisory (March 2003 – March 2006; August 2007 - March 2011)

- Service Line Leadership – Led the "North Florida" service line (Tampa, Orlando, and Jacksonville) for Information Risk Management within external audit clients. Led team responsible for managing over 500 engagements per year
- Revenue Generation and Management – Responsible for selling advisory services (through new client generation, revenue expansion, and new service offerings) throughout Tampa/Orlando/Jacksonville, the Southeast, and HealthCare and Technology companies across the United States
- Engagement Management – Responsible for managing multi-million dollar engagements at 15 to 20 clients per year. Ultimate engagement management responsibility including delivery of contracted services, ensuring client satisfaction, execution within approved budgets, and project quality
- Industry Focus – Primary focus within the healthcare (providers and payors) and technology (software, hardware, IT services, technology distribution, and IT staffing augmentation) industries

WellCare Health Plans, Tampa, FL

Finance Corporate Development Manager (March 2006 – July 2007)

- Served as finance corporate development manager for one of the leading providers of government sponsored health plans. Responsible for the successful delivery of strategic and cross-functional projects in role as lead project manager on strategic projects for Chief Financial Officer.

JDH Consulting

Independent Consultant (November 2001 – February 2003)

- Provided customer service consulting services to Fortune 1000 companies. Scope of engagements included review of insourcing/outsourcing model, operating model re-design, and process improvement opportunities within call center arena. Re-designed call script process for leading handheld technology company that resulted in multi-million dollar savings (annualized).

Intel Corporation

Business Analyst (June 2000 – October 2001)

- Performed analysis of Intel's financial processes as well as the computer systems used to support accounting and finance functions. Responsible for the review of business requirements and the configuration of systems around respective processes. Conduit between programmer analysts and management in the design and day-to-day operations of financial software and systems.

Academic Background

Indiana University
- Bachelor of Science, Business Process Management

References

Timothy J. Gibson. Regional Director, Payer Strategy and Product Development, Trinity Health
- Phone: 515-643-7418
- Address: 1755 59th Place; West Des Moines, IA 50266

Jason Humphrey, Senior Director, Payer Strategy and Contract Management, CHI
- Phone: 515-643-7417
- Address: 1111 6Th Avenue; Des Moines, IA 50314

Josh Kevan, Principal, Sr. Consultant
- Phone: 503-221-4200
- Address: 1211 SW 5th Ave, Suite 900; Portland, OR 97204

ROBERT D. KLOPOTEK

Career History

WellCare Health Plans, Inc., Tampa, FL

Vice President, Information Systems (October 2005 – Present)

- Initial accountability (and successful launch) for all IT aspects of WellCare's national PDP plan, providing solutions for both internal and government partner challenges.
- Assumed responsibility for stabilizing Medicaid enrollment processes for 3 new, large Medicaid plans.
- Successfully led the design, development, and implementation of enterprise-wide Enrollment intake and Correspondence Tracking capabilities supporting both Medicaid and Medicare.
- Corporate Accountability for conducting Regulatory Steering Committee to ensure timely and accurate transition of regulatory changes to system solutions. Includes oversight and delivery for associated projects, ranging from annual AEP and CMS releases to Medicaid Reporting and NPI deployment.
- Assumed responsibility for a large collection of home-grown, surround applications in Delphi. Reduced operating costs and improved productivity by documenting requirements, retiring several applications by eliminating redundancy, and migrating to C#/Oracle during major system upgrade.
- Accountable for all aspects of Core Platform application support. Accomplishments include stabilizing platform and eliminating outages, successfully completing two major upgrades during 3-day weekends without business disruption, and successfully negotiating long-term vendor contract that provides dedicated vendor staff and long-term platform stability at a very affordable cost per member.
- Responsible for primary interactions with operational and product development business units. Approach became the model for the corporate IT Single Point of Contact (SPOC) process.
- Assumed responsibility for operations area and transformed the focus "from IT Operations to Production Control". Includes negotiation, monitoring, and delivery of business-meaningful SLAs as well as 24x7 monitoring of business operations and functions, with playbooks and escalation procedures to ensure effective business outcomes.
- Continually maintain focus on recruitment and staffing activities, placing emphasis on balanced, honest feedback that provides actionable improvement and growth information, a recruitment process that brings in only quality additions, and continuous knowledge transition. Demonstrated through 5 years as IT instructor for internal "Essentials of Managed Care" program, serving as advisor to USF Graduate Student program (2012) student project, and high annual Associate Opinion Survey scores.
- Transitioned to accountability as Chief Architect of WellCare (2014), accountable for Enterprise Architecture and management of Solution Architects to ensure development of robust, scalable applications in support of our government partners.

Amisys Synertech, Inc., Harrisburg, PA

Vice President, Product Engineering (ASI) (October 2003 – October 2005)

- Reporting to CTO, responsible for activities of all software development staff of >70 FTEs and contractors. Primary activities were the successful development and support, in an ASP arrangement, of CDH solutions for 3 early entrants (Lumenos, Definity, HMI) in a 6 month period as well as the migration of the AMISYS application from proprietary HP 3000 to Java/Oracle platform. Both solutions continue to be utilized and generate revenue.
- Continued maintenance and support for all ASP products and solutions, including "HSII", "QMACS", "Pathways Managed Care" platforms and application code.
- Technology platforms supported included MUMPS, Visual Basic/.Net and SQL Server, C++ and Sybase, COBOL and Turbo Image (HP3000), Java/J2EE and Oracle, and web technologies such as JSP, HTML, and Struts Framework.
- Led development and implementation of process improvement and BPM solutions utilizing Microsoft BizTalk to improve claims processing productivity and reduce operational costs.

Chief Information Officer (March 2001 – October 2003)

- Successfully provided and managed all infrastructure and IT components of ASP business operations, running multiple server platforms and operating systems (Compaq Proliant/Windows and HP/HP-UX; also Linux, Sun/Solaris, and HP 3000). Exceeded contractual 99.5% availability standards with actual average of >99.9%.
- Accountable for budget, availability, vendor selection and management functions of delivering seamless implementation and support for all infrastructure components, ranging from network and telecom (internal network, dial up, frame relay, and wireless internet), connectivity (including Citrix and VPN), security (Intrusion Detection, Firewalls, Virus scanning) and data center facilities.
- Led and managed 24x7x365 operations area responsible for tens-of-thousands of weekly job process and file transmission activities. Implemented and met business-driven SLAs for these operations.
- Responsible for all Business Process Outsourcing and Software Development Functions in Pick/Unidata, MUMPS, Oracle and SQL Server along with Lotus Domino, Sybase, and Turbo Image.
- Responsible for IT Policy and Governance including topics such as IT Security and Password, HIPAA, and Change Management policies and leadership and oversight of Corporate Technology Committee.
- Accountable for development, annual testing, and revision of Data Center recovery plan, demonstrating the ability to meet the contractually-obligated 72 hour recovery time objective.
- Led service desk area for >1000 internal users and >2000 external users supporting all application and infrastructure services, managing to aggressive response time and resolution SLAs.

Director, Managed Care Software Development (1996-2001)

- Oversight of software development and maintenance for flagship software offerings. Accountable for budget and delivery obligations of >50 FTEs and contractors supporting

multiple software solutions ("HSII", "QMACS", and "Tingley) and corresponding custom software on multiple technology platforms (including MUMPS, Visual Basic/.Net and SQL Server, Java and Oracle).
- Successfully led the development and implementation of Medicare Part C solutions for new and existing clients in 9 months, including all CMS transactions and formats.
- Supported the Advanced Systems group charged with migrating MUMPS application and code generation tools to object-oriented, Java-based solution.
- Successfully developed and executed skills transition plan of MUMPS and Pick developers to newer technologies, including VB, SQL Server, and object-oriented approaches.
- Leadership and responsibility for EDI and clearinghouse interactions and data file mapping (including HIPAA Transactions) utilizing BizTalk, EZ-Map, and Mercator.

Manager, Software Development (1992-1996)

- Design and Management responsibilities for specified application modules, including new development and maintenance, with accountability for >20 FTEs and contractors.
- Through various restructurings, assumed responsibility for development teams supporting all application modules, including systems and tools functions, improving system design and cohesion.
- Designed, led, and helped develop "Pre-enrollment" module to support individual and Medicaid Market in 3 months, expanding customer market opportunity and reducing operational expense.
- Designed and developed a provider Capitation module that included Fully-Capitated and Episode-of-Care based reimbursement and risk sharing solution in 6 months.

Academic Background

St. Norbert College, DePere, WI
- B.B.A. Accounting with Minor in Computer Science

References

Jim Boyles, President, The Partners of Integrity
- Phone: 717-903-9277
- Address: 437 Woodruff Way; Harrisburg, PA 17112

Louis (Mick) Meckler, President
- Phone: 717-421-1723
- Address: 3824 Chippenham Road; Mechanicsburg, PA 17050

Gina Orellans
- Phone: 813-230-8464
- Address: 16919 Candaleda de Avila; Tampa, FL 33613

RICHARD PETRUCCI, M.D.

Career History

WellCare Health Plans, Inc. Tampa, FL

Vice President, Population Outcomes (February 2015 – Present)

- Provides leadership, develops strategies, coordinates work streams and methodically implements enhancements to the Care Model to enable WellCare members to receive the "Right Care" at the "Right Time" in the Right Place."
- The role develops strategies, coordinates activities, drives objectives and achieves business goals by interacting at 4 points of contact:
    - Interaction with the CMO (Chief Medical Officer) and direct reports of the CMO;
    - Interaction with Market Presidents;
    - Interaction with members of the SMT (Senior Management Team);
    - Has line responsibility for the CSO (Clinical Services Organization) "Population Health & Quality staff.

New York State Medical Director (January 2013 – February 2015)

- Leader of New York Quality Improvement Team, responsible for the State specific Medicare STAR and Medicaid Quality (QARR) measure results.
- Leads QI team in root cause/barrier analysis of individual results by Line of Business (LOB), designs interventions to address barriers and implements program to improve quality scores. Leader Field-Based Case Management Team provided Clinical Leadership for Field-based team that meets Face-to-Face with members & their families/support systems, that attends Member Physician appointments post-hospital discharge & that coordinates all Care Services including social service, transportation, housing, etc.
- Clinical Lead for development of the Regional Dashboard and IPA management strategy analysis used to improve IPA performance.
- Clinical Lead for Corporate Telephonic Case Management and Disease Management Team – Redesigned disease specific assessment, workflows and interventions.
- Redesigned program metrics to align focus on improving HEDIS results, reducing hospital re-admissions, reducing preventable admission and improving medication adherence to improve overall Medicare STAR and Medicaid Quality sores.

MannKind Corporation, Valencia, CA

Vice President, Medical Affairs (April 2008 – January 2013)

Leader AFREZZA (Technosphere insulin) Product Development and New Drug Application (NDA) Team:

- Clinical Lead for all clinical interactions with FDA:

  - Clinical Lead for Type C meeting with FDA held in August 2011 – defended new MannKind Phase 3 Clinical Trials designs and successfully negotiated final design agreed upon with FDA creating a clear path forward for product approval
  - Clinical Lead at second End of Review meeting with FDA held in May 2011 – defended and negotiated design and implementation of new clinical trials needed to satisfy the second Complete Response Letter (CRL) from FDA received January 2011.
  - Member of 8 person team for first End of Review meeting with FDA. Represented MannKind at the End of Review meeting with the FDA and addressed the concerns regarding the efficacy of AFREZZA with the members of the FDA's team.
- Clinical Lead for AFREZZA Clinical Trial Program:
  - Responsible for the development, implementation and execution of new Phase 3 clinical trial program required to satisfy the FDA requirements outlined in the CRL.
- Clinical Lead responsible for filing of NDA:
  - Leader of the 5 person Integrated Summary of Efficacy (ISE) Writing Team which was responsible for developing the strategy on how to present the efficacy data and for executing on the production of the ISE document in a timely manner to meet the regulatory requirements to demonstrate product efficacy.

Head - Biostatistics and Data Management Group:

- Clinical Head of BioMetrics Team that was responsible for the selection, implementation and analysis of all hardware and software tools needed for the execution of the clinical trial program and submission of the AFREZZA NDA.
- Responsible for department of 6 FTE statisticians and SAS programmers.

Clinical Lead - AFREZZA Product Commercialization Team:

- Medical lead on product partnership team – responsible for efficacy presentations and review of all efficacy materials and data with potential business partners.
- Key Opinion Leader (KOL) advisory Board activities – partnered with Commercial Team to set agendas, create presentations, present data and provide KOL feedback to the company
- Active member of the Pricing and Reimbursement team
- Assists Commercial Team with the development of market research tools for patients, physicians and payers.

Head - Scientific Publications:

- Manager of 3 person team responsible for all company-wide publications including abstracts and manuscripts. In 2009, team was responsible for presenting 12 abstracts and 2 oral presentations at the annual ADA meeting as well as 14 at the EASD meeting and the publication of 3 manuscripts. In 2010, team had 10 abstracts and 3 oral presentation accepted. In addition, several manuscripts have been submitted for publications including one which has been accepted by the Lancet for publication in June 2010.

Senior Director, Diabetes Clinical Research and Development (April 2007 – April 2008)

- Responsible for the generation of all scientific publications for MannKind's products – this included the generation of all abstracts for publication at national/worldwide conferences such as the ADA and EASD meetings as well as the full manuscript publication in journals such as Diabetes Care and Diabetoligica.
- Responsible for the creation of CME programs in the area of diabetes care with particular focus on the importance and use of prandial insulins in Type 2 Diabetes.
- Responsible for the development, the management and oversight of all Key Opinion Leader advisory boards – focused in the areas of Endocrinology, Pulmonology and Primary Care Medicine. Worked with the Medical Writing and Commercial Brand Teams in the development of MannKind's diabetes advisory boards and plays an active role in their execution.

Academic Background

Albert Einstein College of Medicine, Bronx, NY
- Rheumatology Fellowship

North Shore University Hospital, Manhasset, NY
- Internal Medicine Residency

New York Medical College, Valhalla, NY
- Doctor of Medicine

Williams College, Williamstown, MA
- B.A., Biology

References

Dr. Marc Tack, DO
- Phone: 845-338-7140
- Address: 360 Washington Ave; Kingston, NY 12401

Dr. Deepak Patel, MD
- Phone: 845-339-5100
- Address: 518 Broadway; Kingston, NY 12401

Dr. Maria David, MD
- Phone: 845-565-5437
- Address: 266 North St.; Newburgh, NY 12550

MARCIA LELIS WELCH, RN, BSN, CCM

Career History

WellCare Health Plans, Inc., Tampa, FL

Vice President, Clinical Services (April 2014 – Present)

- Directs the plan's health services function which may include pre-authorization, concurrent review, complex case management, quality improvement, credentialing, health and wellness and disease management.
- Oversight of the overall coordination, implementation and monitoring of activities to yield quality driven, compliant, efficient and cost-effective results.

Aetna/CoventryCares of Kentucky, Louisville, KY

Vice President, Health Services (August 2012 – April 2014)

- Direct report to the Chief Medical Officer to meet targets for inpatient bed days, meeting Medical Loss Ratio targets and increasing quality of care for members, developing and adhering to the budget for the Health Services Department and oversight of the corporate case management programs, and for developing programs specific to the needs of the Kentucky population.

Select Health of South Carolina, Charleston, SC

Regional Clinical Lead for the Southern Region (February 2012 – August 2012)

- The parent company, AmeriHealth Mercy, expanded into additional states creating the need to expand the scope of the then current clinical lead position in South Carolina. Responsible for oversight and development of the Utilization Management, Case Management, Maternal Child Case Management, Rapid Response Unit and the Appeals Department for all 3 states, including developing the budget for all three states. A total of 380,000 Medicaid/SCHIP members were managed between the plans.

Senior Director, Medical Services (September 2008 – February 2012)

- Responsible for designing and implementing policies and procedures for our UM, CM and DM departments, which contributed to their obtaining their initial NCQA accreditation, budgetary oversight, monitoring of under and over utilization and development of productivity standards. Areas of responsibility included Case Management, Disease Management, Maternal Child Case Management, Utilization Management, Provider Appeals and Delegated Onsite activities for external vendors for Behavioral Health and High Tech Imaging for a 170,000 member Medicaid Program, in addition to managing the new SCHIP membership in South Carolina.

Health Integrated, Tampa, Florida

Senior Director, Behavioral Health Utilization Management and Case Management (January 2008 - June 2008)

- Areas of responsibility included Behavioral Health Utilization Management and Case Management for a combination of Commercial, Medicaid and Medicare Advantage members.

BlueCross BlueShield of Tennessee, Chattanooga, TN

Director/Senior Manager for Medical Management (October 2006 – November 2007)

- Responsible for the continued development of the Medicaid (BlueCare) line of business for 600,000 members; development of the Medical Management platform for the newly assigned SCHIP members; and the development of two commercial products to offer to Tennessee's low-income uninsured and the uninsurable populations (Cover Tennessee).

- Senior Managers and Managers over Utilization Management, Disease Management, Case Management, Care Coordination, Member Outreach, Member Appeals, Provider Appeals, Retrospective and Pre-existing Reviews, Systems and Education, and the Senior Manager who coordinated Behavioral Health Services with the State's Behavioral Health Organization reported to this position. Responsible for developing the budgets for all 4 lines of business for the Medical Management areas.

Senior Manager, Commercial Medical Management Division (2005 – 2006)

- Responsible for oversight and continued development of the Utilization Management, Case Management, Catastrophic Case Management, Care Coordination, Transplant Case Management, High Risk OB Case Management areas, including managing the Federal Employees (FEP) medical management department, for a total of 1.6 million lives. Responsible for the budget for this department's Medical Management Division and meeting medical management targets.

- Three highlights during this period were our department's development of a DVT prevention program, an end-stage support program (HOPE), which focused on Hospice, Oncology, Palliative Care and End State Disease, and participation in the design, development and implementation of Custom Care Solutions, a programmed designed to meet the needs of one of our large municipal accounts with high cost members to reward members for participation in the case management program, with a focus on referring members to best-practice practitioners.

Senior Manager, Medical Management (1999-2005)

- During this period all of the medical management departments at BlueCross Blue Shield of Tennessee were combined into one department, with management being divided into East

and West. This position was responsible for providing direction and management for the eastern part of Tennessee, which included Commercial and Medicaid lines of business. In addition, the Eastern Division managed Security Blue, an HMO Medicare Product which was just available to members residing in one geographical section of the eastern part of the state. 1.4 million lives were managed for the eastern part of the state.

Manager, Clinical Services, Medicaid Division (1997 – 1999)

- Manager for all of the medical management staff who worked in the areas of Utilization Management, Case Management, Provider Appeals, Member Outreach, and Demand Management (our internal 24/7 Nurse Line) for a membership of 600,000. During 1996/1997 the Case Management and Demand Management departments were created for the Medicaid population. The Utilization Management function for Medicaid was transitioned from the Commercial side.

Academic Background

Jacksonville University, Jacksonville, FL
- B.S., Nursing

Cleveland State Community College, Cleveland, TN
- A.S., Business Administration
- A.S., Nursing

References

Karin Ferguson, QI Corporate VP, AmeriGroup
- Phone: 804-304-3388
- Address: 7365 Prairie Road; Richmond, VA 23225

Fred Volkman, MD
- Phone: 843-697-5589
- Address: 5407 Henrietta Hartford Road; Mount Pleasant, SC 29466

Peggy Vickery, Director of Provider Relations, Select Health
- Phone: 843-270-0286
- Address: 233 Tall Sail Drive, E.; Charleston, SC 29414

ATTACHMENT 5

5. Submit preliminary implementation plan as described in Section IV.X - Transition and Implementation.

Please see our preliminary implementation plan attached herein.

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
1	**Nebraska**	**360 days**	**Fri 01/01/16**	**Thu 05/18/17**
2	**Contract / Procurement**	**236 days**	**Fri 02/05/16**	**Fri 12/30/16**
3	Letter of Intent to Contract	1 day	Fri 02/05/16	Fri 02/05/16
4	Contract Award	1 day	Tue 03/15/16	Tue 03/15/16
5	Contract Execution	10 days	Mon 12/19/16	Fri 12/30/16
6	**PMO Activities**	**360 days**	**Fri 01/01/16**	**Thu 05/18/17**
7	Identify Project Manager	20 days	Fri 01/01/16	Thu 01/28/16
8	Write Project Charter	35 days	Fri 01/29/16	Thu 03/17/16
9	Create RACI Chart	36 days	Mon 02/08/16	Mon 03/28/16
10	Configure SharePoint Site	10 days	Mon 01/18/16	Fri 01/29/16
11	Identify Business Requirements/Gaps	60 days	Mon 02/01/16	Fri 04/22/16
12	Schedule Weekly Work Stream Meetings	196 days	Fri 04/01/16	Fri 12/30/16
13	Establish Weekly Status Reporting from Work Stream Areas	196 days	Fri 04/01/16	Fri 12/30/16
14	Establish Weekly Status Reporting to PMO Management	295 days	Fri 04/01/16	Thu 05/18/17
15	Update Implementation Plan	219 days	Tue 03/01/16	Fri 12/30/16
16	Transition Plan for Termination	20 days	Fri 04/01/16	Thu 04/28/16
17	**Contract to Pay**	**245 days**	**Mon 03/07/16**	**Fri 02/10/17**
18	**Customer Service / Member Services**	**179 days**	**Mon 04/11/16**	**Thu 12/15/16**
19	**LOB / Plan Codes**	**22 days**	**Mon 05/16/16**	**Tue 06/14/16**
20	Create LOB	2 days	Mon 05/16/16	Tue 05/17/16
21	Create Plan Codes	4 days	Fri 06/03/16	Wed 06/08/16
22	Assign Plan Codes to LOB	4 days	Thu 06/09/16	Tue 06/14/16
23	**Staffing and Call Center Build**	**88 days**	**Mon 06/13/16**	**Wed 10/12/16**
24	Forecast # CSR's - go live	88 days	Mon 06/13/16	Wed 10/12/16
25	Create Call forecast in IEX	88 days	Mon 06/13/16	Wed 10/12/16
26	**Customer Service Training**	**90 days**	**Mon 06/27/16**	**Fri 10/28/16**
27	Develop CS Product Training	90 days	Mon 06/27/16	Fri 10/28/16
28	Develop a Helpline Back Up Plan	60 days	Mon 08/08/16	Fri 10/28/16
29	**Telecom**	**179 days**	**Mon 04/11/16**	**Thu 12/15/16**
30	**Toll free CS line with after hours voice mailbox**	**119 days**	**Mon 07/04/16**	**Thu 12/15/16**
31	Develop call tree to route BH and LTSS member calls and provider calls	80 days	Mon 07/04/16	Fri 10/21/16
32	UAT	20 days	Mon 10/24/16	Fri 11/18/16
33	Move to Production	4 days	Mon 12/05/16	Thu 12/08/16
34	Setup TDD service	4 days	Mon 12/12/16	Thu 12/15/16
35	**Hardware and Software**	**165 days**	**Mon 04/11/16**	**Fri 11/25/16**
36	Identify hardware requirements	60 days	Mon 04/11/16	Fri 07/01/16
37	Identify software requirements	60 days	Mon 04/11/16	Fri 07/01/16
38	Submit intake request	40 days	Mon 07/04/16	Fri 08/26/16
39	Receive equipment	45 days	Mon 07/04/16	Fri 09/02/16
40	System configuration	50 days	Mon 09/19/16	Fri 11/25/16

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
41	**CAREConnects**	**151 days**	**Mon 05/02/16**	**Mon 11/28/16**
42	Build & Load member & provider call flows	80 days	Mon 05/02/16	Fri 08/19/16
43	Update Customer Form with new LOB	55 days	Mon 06/13/16	Fri 08/26/16
44	**Update Policies and Procedures**	**120 days**	**Mon 05/02/16**	**Fri 10/14/16**
45	Identify all P & Ps to be Updated/Created	34 days	Mon 05/02/16	Thu 06/16/16
46	Update P & Ps	70 days	Mon 06/06/16	Fri 09/09/16
47	Route for Internal Department Approval	45 days	Mon 08/01/16	Fri 09/30/16
48	Route through C360 Process for Final Approval	30 days	Mon 09/05/16	Fri 10/14/16
49	**Update call tools (SATs, etc) in WCL**	**110 days**	**Tue 06/28/16**	**Mon 11/28/16**
50	Identify all docs to be Updated/Created	110 days	Tue 06/28/16	Mon 11/28/16
51	Update/create call tools	110 days	Tue 06/28/16	Mon 11/28/16
52	**Tracking and Reporting**	**100 days**	**Mon 07/11/16**	**Fri 11/25/16**
53	Maintain call types report per Reporting Manual	100 days	Mon 07/11/16	Fri 11/25/16
54	**Provider Operations**	**195 days**	**Mon 04/04/16**	**Fri 12/30/16**
55	**Capitation**	**195 days**	**Mon 04/04/16**	**Fri 12/30/16**
56	Submit capitation contracts to Capitation team	190 days	Mon 04/04/16	Fri 12/23/16
57	Configure and load custom capitation contracts	190 days	Mon 04/11/16	Fri 12/30/16
58	**Operations**	**34 days**	**Mon 06/06/16**	**Thu 07/21/16**
59	Submit provider agreements	0 days	Mon 06/06/16	Mon 06/06/16
60	Provider Communication Strategy	1 day	Mon 06/06/16	Mon 06/06/16
61	Provider Manual	34 days	Mon 06/06/16	Thu 07/21/16
62	Training Plan for Providers	34 days	Mon 06/06/16	Thu 07/21/16
63	**Benefits Configuration**	**151 days**	**Fri 06/03/16**	**Fri 12/30/16**
64	Create Plan Codes/Group IDs in test environment	59 days	Fri 06/03/16	Wed 08/24/16
65	Create Plan Codes/Group IDs in production	20 days	Fri 06/03/16	Thu 06/30/16
66	Create BML (1st draft)	65 days	Mon 06/20/16	Fri 09/16/16
67	Finalize BMLs	55 days	Fri 09/16/16	Thu 12/01/16
68	Configure BML & QRG into test environment	55 days	Mon 10/10/16	Fri 12/23/16
69	Configure authorization waivers in test environment	50 days	Mon 10/17/16	Fri 12/23/16
70	Test benefits and authorizations - unit testing	50 days	Mon 10/24/16	Fri 12/30/16
71	Configure Benefits and authorizations in production	50 days	Mon 10/24/16	Fri 12/30/16
72	**Fee Schedules**	**136 days**	**Mon 06/06/16**	**Mon 12/12/16**
73	Identify custom Fee Schedules	59 days	Mon 06/06/16	Thu 08/25/16
74	Configure custom Fee Schedules	77 days	Fri 08/26/16	Mon 12/12/16
75	**Provider Configuration**	**118 days**	**Mon 05/09/16**	**Wed 10/19/16**

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Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
76	Configure providers - Institutional team	118 days	Mon 05/09/16	Wed 10/19/16
77	Configure providers - Professional team	118 days	Mon 05/09/16	Wed 10/19/16
78	**EDI Configuration**	**114 days**	**Mon 07/11/16**	**Thu 12/15/16**
79	SNIP Analysis on inbound 837	64 days	Mon 07/11/16	Thu 10/06/16
80	Create SNIP test scenarios	57 days	Mon 08/15/16	Tue 11/01/16
81	Test SNIPs for new LOB	74 days	Mon 09/05/16	Thu 12/15/16
82	**Network Report**	**1 day**	**Mon 04/18/16**	**Mon 04/18/16**
83	Geo Report Weekly	1 day	Mon 04/18/16	Mon 04/18/16
84	**Network Contract**	**30 days**	**Mon 08/08/16**	**Fri 09/16/16**
85	Major Hospital Systems	30 days	Mon 08/08/16	Fri 09/16/16
86	Medicaid Providers	30 days	Mon 08/08/16	Fri 09/16/16
87	HCBS Providers	30 days	Mon 08/08/16	Fri 09/16/16
88	PH Providers	30 days	Mon 08/08/16	Fri 09/16/16
89	Pharmacy	20 days	Mon 08/08/16	Fri 09/02/16
90	National	20 days	Mon 08/08/16	Fri 09/02/16
91	**Contract Distribution**	**54 days**	**Mon 06/06/16**	**Thu 08/18/16**
92	Obtain UPH Employed and Affiliated Facilities and Providers	4 days	Mon 08/08/16	Thu 08/11/16
93	Add Providers with the Networks	5 days	Mon 08/08/16	Fri 08/12/16
94	Obtain Roster of Nebraska FFS Registered Providers	1 day	Mon 06/06/16	Mon 06/06/16
95	BH Network Plan- Finalize List of Required BH Providers	2 days	Mon 08/08/16	Tue 08/09/16
96	BH Network Plan- De-duplicate and Establish Contract List	2 days	Mon 08/08/16	Tue 08/09/16
97	BH Network Plan- Provide Resource Need	1 day	Mon 08/08/16	Mon 08/08/16
98	National Contracting- Establishment of Specialties to be covered by National Ancill	4 days	Mon 08/15/16	Thu 08/18/16
99	Pharmacy- Establish Network	10 days	Mon 07/11/16	Fri 07/22/16
100	**Contract Load**	**26 days**	**Mon 05/16/16**	**Mon 06/20/16**
101	Create Provider Mailing List	2 days	Mon 06/13/16	Tue 06/14/16
102	Coordination of Materials	4 days	Mon 05/16/16	Thu 05/19/16
103	Outbound Phone Calls to Ensure Packets	5 days	Tue 06/14/16	Mon 06/20/16
104	Create PLFs	2 days	Tue 06/14/16	Wed 06/15/16
105	**Vendor Network Development**	**55 days**	**Mon 05/16/16**	**Fri 07/29/16**
106	Benefits Received from Product	1 day	Mon 05/16/16	Mon 05/16/16
107	RFQs Sent to Capitated Vendors	4 days	Mon 06/06/16	Thu 06/09/16
108	Vendors Confirmed	20 days	Mon 06/13/16	Fri 07/08/16
109	Vendors Begin Network Build	10 days	Mon 06/13/16	Fri 06/24/16
110	Vendors Complete Network Build	20 days	Mon 07/04/16	Fri 07/29/16
111	**Claims**	**175 days**	**Mon 05/02/16**	**Fri 12/30/16**

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
112	Enable processing/reprocessing	58 days	Mon 10/03/16	Wed 12/21/16
113	Establish process to notify providers of patient liability to be collected	61 days	Mon 09/26/16	Mon 12/19/16
114	Readiness review prep (Claims)	46 days	Mon 09/05/16	Mon 11/07/16
115	Update Policies & Procedures	86 days	Mon 07/04/16	Mon 10/31/16
116	Build initial claims tracking reports	17 days	Mon 10/03/16	Tue 10/25/16
117	Update/Create SATs	24 days	Mon 10/17/16	Thu 11/17/16
118	Build test cases	22 days	Mon 10/24/16	Tue 11/22/16
119	Claims testing	21 days	Mon 11/14/16	Mon 12/12/16
120	High volume provider testing	23 days	Mon 11/21/16	Wed 12/21/16
121	**Coordination of Benefits**	**147 days**	**Mon 05/02/16**	**Tue 11/22/16**
122	P & Ps	120 days	Mon 05/02/16	Fri 10/14/16
123	Ensure process is in place to coordinate with other payers	57 days	Mon 09/05/16	Tue 11/22/16
124	**Billing**	**80 days**	**Mon 09/12/16**	**Fri 12/30/16**
125	Establish process to track member cost sharing	75 days	Mon 09/19/16	Fri 12/30/16
126	Establish billing and recon processes to collect premiums	75 days	Mon 09/12/16	Fri 12/23/16
127	Set up copayments for participants	75 days	Mon 09/12/16	Fri 12/23/16
128	**Audit & Recovery**	**169 days**	**Mon 05/02/16**	**Thu 12/22/16**
129	Update overpayment recovery process	99 days	Mon 08/08/16	Thu 12/22/16
130	Update monthly TPL and newborn State reporting	99 days	Mon 08/08/16	Thu 12/22/16
131	Conduct new business audit after full integration	99 days	Mon 08/08/16	Thu 12/22/16
132	Update P & Ps	120 days	Mon 05/02/16	Fri 10/14/16
133	**Third Party Liability Processing**	**170 days**	**Tue 05/03/16**	**Mon 12/26/16**
134	Ensure P & P Compliance	119 days	Tue 05/03/16	Fri 10/14/16
135	Set up weekly TPL data reporting to MLTC	75 days	Tue 09/13/16	Mon 12/26/16
136	**Network Adequacy**	**220 days**	**Mon 04/11/16**	**Fri 02/10/17**
137	Online directory tested/verified	75 days	Mon 09/12/16	Fri 12/23/16
138	Printed directory creation	74 days	Mon 09/05/16	Thu 12/15/16
139	Update validation reports	49 days	Tue 10/25/16	Fri 12/30/16
140	Post go-live claims monitoring (30 days post go-live)	30 days	Mon 01/02/17	Fri 02/10/17
141	Network Adequacy Plan	54 days	Mon 04/11/16	Thu 06/23/16
142	Primary Care Providers	1 day	Mon 06/06/16	Mon 06/06/16
143	Utilization of Urgent Care Clinics Plan	1 day	Mon 06/13/16	Mon 06/13/16
144	Partner with Community Entities	13 days	Mon 07/18/16	Wed 08/03/16
145	**Credentialing**	**145 days**	**Mon 05/02/16**	**Fri 11/18/16**
146	Identify Nebraska specific credentialing requirements	91 days	Mon 05/09/16	Mon 09/12/16
147	Update P & Ps	120 days	Mon 05/02/16	Fri 10/14/16
148	Exclusion checks	57 days	Mon 07/11/16	Tue 09/27/16

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ID	Task Name	Duration	Start	Finish
149	Establish plan for educating non-licensed providers	75 days	Mon 08/08/16	Fri 11/18/16
150	**Product**	**80 days**	**Mon 03/07/16**	**Fri 06/24/16**
151	**Update benefit grids**	**80 days**	**Mon 03/07/16**	**Fri 06/24/16**
152	Review benefits listed in RFP	70 days	Mon 03/07/16	Fri 06/10/16
153	Determine with the market if Expanded benefits/Special Programs will be offered	70 days	Mon 03/14/16	Fri 06/17/16
154	Complete draft of benefit grid for the website	60 days	Mon 04/04/16	Fri 06/24/16
155	Review BML	8 days	Mon 05/23/16	Wed 06/01/16
156	Approve BML	4 days	Mon 06/06/16	Thu 06/09/16
157	Draft Changes in Covered Services letter	5 days	Fri 06/10/16	Thu 06/16/16
158	Obtain approval of Changes in Covered Services letter from MLTC	4 days	Mon 06/20/16	Thu 06/23/16
159	**Enrollment/IT Support**	**41 days**	**Mon 04/18/16**	**Mon 06/13/16**
160	Receive Group ID's and Plan codes from Config	0 days	Mon 04/18/16	Mon 04/18/16
161	Create ID Card Table	5 days	Mon 05/09/16	Fri 05/13/16
162	Create CTS Plan Master Table	4 days	Mon 05/23/16	Thu 05/26/16
163	Create Data Crosswalk Table	4 days	Mon 06/06/16	Thu 06/09/16
164	Disseminate for BML Table Updates	1 day	Mon 06/13/16	Mon 06/13/16
165	**Program integrity plan**	**140 days**	**Mon 04/18/16**	**Fri 10/28/16**
166	Coordination of Program Integrity Efforts	139 days	Mon 04/18/16	Thu 10/27/16
167	**Fraud and Abuse Activities**	**125 days**	**Mon 05/09/16**	**Fri 10/28/16**
168	Plan for reporting Fraud and Abuse	20 days	Mon 05/09/16	Fri 06/03/16
169	Verification of services provided	10 days	Mon 06/06/16	Fri 06/17/16
170	P & Ps outlining compliance with federal and state laws	20 days	Mon 10/03/16	Fri 10/28/16
171	**National Ancillary**	**130 days**	**Mon 07/04/16**	**Fri 12/30/16**
172	Select delegated and ancillary vendors	79 days	Mon 07/04/16	Thu 10/20/16
173	Send delegated and ancillary vendor agreements	56 days	Mon 08/08/16	Mon 10/24/16
174	Send credentialing application to delegated and ancillary vendors	56 days	Mon 08/22/16	Mon 11/07/16
175	Create and send PLF to load contracts	99 days	Mon 08/15/16	Thu 12/29/16
176	Set up TPV files	99 days	Mon 08/15/16	Thu 12/29/16
177	Train delegated and ancillary vendors	95 days	Mon 08/22/16	Fri 12/30/16
178	Cap model/payment	110 days	Mon 08/01/16	Fri 12/30/16
179	**Care Coordination / Management**	**194 days**	**Mon 04/04/16**	**Thu 12/29/16**
180	**Clinical Services Organization**	**187 days**	**Mon 04/04/16**	**Tue 12/20/16**
181	Welcome call and initial health risk screening document and procedure	167 days	Mon 04/04/16	Tue 11/22/16
182	Comprehensive health risk assessment document and procedure	167 days	Mon 05/02/16	Tue 12/20/16

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ID	Task Name	Duration	Start	Finish
183	Care plan development	167 days	Mon 05/02/16	Tue 12/20/16
184	Reassessment document and procedure	167 days	Mon 05/02/16	Tue 12/20/16
185	Care coordination program including monitoring for program effectiveness	167 days	Mon 05/02/16	Tue 12/20/16
186	Disease management procedure	167 days	Mon 05/02/16	Tue 12/20/16
187	Utilization Management Program	167 days	Mon 05/02/16	Tue 12/20/16
188	Precert & NOA letters	167 days	Mon 05/02/16	Tue 12/20/16
189	Continuity of Care P & Ps	120 days	Mon 05/02/16	Fri 10/14/16
190	Change in Community-Based Case manager Transition Plan	1 day	Wed 10/05/16	Wed 10/05/16
191	Sustainability Plan with no MFP Gran Plan	1 day	Wed 10/05/16	Wed 10/05/16
192	Initial Health Risk Screening	1 day	Wed 10/05/16	Wed 10/05/16
193	Initial Health Risk Screening Tool	1 day	Wed 10/05/16	Wed 10/05/16
194	Needs Assessment	1 day	Wed 10/05/16	Wed 10/05/16
195	Coordination with Medicare and Medicaid Duals	1 day	Wed 10/05/16	Wed 10/05/16
196	Timeframe of Needs Assessments	1 day	Wed 10/05/16	Wed 10/05/16
197	PASRR Process	1 day	Wed 10/05/16	Wed 10/05/16
198	Community-Based Case Manager Qualifications	1 day	Wed 10/05/16	Wed 10/05/16
199	Seamless Transition of Change in CBCM	1 day	Wed 10/05/16	Wed 10/05/16
200	Institutional Diversion Program	1 day	Wed 10/05/16	Wed 10/05/16
201	Identifying Members Transition from Nursing Facility or ICF/ID	1 day	Wed 10/05/16	Wed 10/05/16
202	**Pharmacy**	**194 days**	**Mon 04/04/16**	**Thu 12/29/16**
203	**Formulary Management**	**171 days**	**Mon 05/02/16**	**Mon 12/26/16**
204	Obtain benefit design	140 days	Mon 06/06/16	Fri 12/16/16
205	Obtain PDL/RDL	140 days	Mon 06/06/16	Fri 12/16/16
206	Decision on transition policy	140 days	Mon 06/06/16	Fri 12/16/16
207	Establish pharmacy network	101 days	Mon 07/04/16	Mon 11/21/16
208	Rebate contracts	101 days	Mon 07/11/16	Mon 11/28/16
209	Website - pharmacy related	116 days	Mon 06/13/16	Mon 11/21/16
210	Provider/Member communications - all forms	57 days	Mon 07/18/16	Tue 10/04/16
211	Create member eligibility files	111 days	Mon 07/25/16	Mon 12/26/16
212	State/Regulatory reporting - pharmacy related	101 days	Mon 07/18/16	Mon 12/05/16
213	Ensure P & P Compliance	120 days	Mon 05/02/16	Fri 10/14/16
214	Create Step Action Table	102 days	Mon 07/25/16	Tue 12/13/16
215	Pharmacy Prior Auth process	101 days	Mon 07/18/16	Mon 12/05/16
216	Drug Utilization Review (DUR) Program	101 days	Mon 07/11/16	Mon 11/28/16
217	Utilization Management Programs	101 days	Mon 07/18/16	Mon 12/05/16
218	Pharmacy Access	101 days	Mon 07/18/16	Mon 12/05/16
219	Reimbursements	101 days	Mon 07/18/16	Mon 12/05/16

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ID	Task Name	Duration	Start	Finish
220	Pharmacy Encounters Claims Submission	101 days	Mon 07/18/16	Mon 12/05/16
221	DER	110 days	Mon 07/25/16	Fri 12/23/16
222	Appeals	110 days	Mon 07/25/16	Fri 12/23/16
223	DMR process changes	110 days	Mon 07/25/16	Fri 12/23/16
224	**Pharmacy Operations**	**194 days**	**Mon 04/04/16**	**Thu 12/29/16**
225	Prior Authorizations	101 days	Mon 07/25/16	Mon 12/12/16
226	Training	99 days	Mon 08/15/16	Thu 12/29/16
227	Reports	100 days	Mon 07/18/16	Fri 12/02/16
228	Call Center Location	66 days	Mon 04/18/16	Mon 07/18/16
229	Develop Training	36 days	Fri 07/01/16	Fri 08/19/16
230	Hours of Operations	100 days	Mon 04/04/16	Fri 08/19/16
231	**Appeals**	**149 days**	**Mon 06/06/16**	**Thu 12/29/16**
232	**Update Training/SAT's**	**119 days**	**Mon 07/18/16**	**Thu 12/29/16**
233	Create Job Aids and SAT's	119 days	Mon 07/18/16	Thu 12/29/16
234	**Develop appeals Regulatory Reporting**	**97 days**	**Mon 08/15/16**	**Tue 12/27/16**
235	Review Reporting Manual	97 days	Mon 08/15/16	Tue 12/27/16
236	**Member/Provider Appeal Letters**	**102 days**	**Mon 08/08/16**	**Tue 12/27/16**
237	Develop member/provider appeal letter templates	99 days	Mon 08/08/16	Thu 12/22/16
238	Submit letter templates to the State for review and approval	77 days	Mon 09/12/16	Tue 12/27/16
239	**Develop/Update P & P**	**95 days**	**Mon 06/06/16**	**Fri 10/14/16**
240	Update Policy with new contract requirements	70 days	Mon 06/06/16	Fri 09/09/16
241	Upload updated Policy into C-360	70 days	Tue 06/07/16	Sat 09/10/16
242	RA Review and Approval	45 days	Mon 08/01/16	Fri 09/30/16
243	Receive 1st Level approval and finalize P & P process	30 days	Mon 09/05/16	Fri 10/14/16
244	**Grievances**	**144 days**	**Mon 06/06/16**	**Thu 12/22/16**
245	**Develop/Update P & P**	**95 days**	**Mon 06/06/16**	**Fri 10/14/16**
246	Update Policy with new contract requirements	70 days	Mon 06/06/16	Fri 09/09/16
247	Upload updated Policy into C-360	60 days	Mon 06/20/16	Fri 09/09/16
248	RA Review and Approval	45 days	Mon 08/01/16	Fri 09/30/16
249	Receive 1st Level approval and finalize P & P process	30 days	Mon 09/05/16	Fri 10/14/16
250	**Update Training & applicable SAT/Job Aids**	**118 days**	**Mon 06/20/16**	**Wed 11/30/16**
251	Create Job Aids and Step Actions	118 days	Mon 06/20/16	Wed 11/30/16
252	**Develop Grievance Regulatory Reporting**	**97 days**	**Mon 07/18/16**	**Tue 11/29/16**
253	Review reporting template with IT Business Analyst, Developers, RA and Market	97 days	Mon 07/18/16	Tue 11/29/16
254	**Member/Provider Grievance Letters**	**114 days**	**Mon 07/18/16**	**Thu 12/22/16**
255	create letters	114 days	Mon 07/18/16	Thu 12/22/16

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ID	Task Name	Duration	Start	Finish
256	**Training**	**134 days**	**Tue 06/28/16**	**Fri 12/30/16**
257	**Training - OPS**	**70 days**	**Mon 07/04/16**	**Fri 10/07/16**
258	Create Operations Training	53 days	Mon 07/04/16	Wed 09/14/16
259	Contract requirements and State and Federal requirements specific to job functions	70 days	Mon 07/04/16	Fri 10/07/16
260	Contractor's policies and procedures on advance directives	35 days	Mon 07/04/16	Fri 08/19/16
261	Initial and ongoing training on identifying and handling quality of care concerns	70 days	Mon 07/04/16	Fri 10/07/16
262	Cultural sensitivity training	70 days	Mon 07/04/16	Fri 10/07/16
263	Fraud and abuse and the False Claims Act	70 days	Mon 07/04/16	Fri 10/07/16
264	HIPAA	70 days	Mon 07/04/16	Fri 10/07/16
265	Interpretation and application of utilization management guidelines for all utilization management staff	70 days	Mon 07/04/16	Fri 10/07/16
266	Assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers	70 days	Mon 07/04/16	Fri 10/07/16
267	Understanding abuse, neglect, exploitation and prevention including the detection, reporting, investigation and remediation procedures and requirements	70 days	Mon 07/04/16	Fri 10/07/16
268	Credentialing Training	70 days	Mon 07/04/16	Fri 10/07/16
269	Critical Incident Training	70 days	Mon 07/04/16	Fri 10/07/16
270	Abuse and Neglect Training	70 days	Mon 07/04/16	Fri 10/07/16
271	IS Contingency and Continuity Training	70 days	Mon 07/04/16	Fri 10/07/16
272	Cultural competence	70 days	Mon 07/04/16	Fri 10/07/16
273	Clinical Protocol Training for all Clinical Staff	70 days	Mon 07/04/16	Fri 10/07/16
274	Finalize Training for Distribution	55 days	Mon 07/04/16	Fri 09/16/16
275	**Business Training**	**134 days**	**Tue 06/28/16**	**Fri 12/30/16**
276	Meet with Market Leadership to discuss market training needs and materials (incl Customer Service, Enrollment, Plan Benefits, etc)	120 days	Mon 07/04/16	Fri 12/16/16
277	Receive initial Provider Orientation from market leadership prior to approval from State (starting point)	130 days	Mon 07/04/16	Fri 12/30/16
278	Compare Provider Orientation to RFP to identify gaps	110 days	Mon 08/01/16	Fri 12/30/16
279	Send Training Plan and Curriculum to Market for Review	110 days	Mon 08/01/16	Fri 12/30/16
280	Add missing elements	110 days	Mon 08/01/16	Fri 12/30/16
281	Meet with Market Leadership to discuss status of market training needs	110 days	Mon 08/01/16	Fri 12/30/16

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ID	Task Name	Duration	Start	Finish
282	Departments to identify potential training needs	130 days	Mon 07/04/16	Fri 12/30/16
283	Add dates and locations to Training Plan	110 days	Mon 08/01/16	Fri 12/30/16
284	Submit for approval	110 days	Mon 08/01/16	Fri 12/30/16
285	Market approves revised Provider Orientation	110 days	Mon 08/01/16	Fri 12/30/16
286	Review P & Ps and make edits as needed	107 days	Mon 07/18/16	Tue 12/13/16
287	Submit P & Ps to state	36 days	Fri 10/14/16	Fri 12/02/16
288	Reach out to Product Team on what is needed to develop Cultural Competency deck	123 days	Tue 06/28/16	Thu 12/15/16
289	Publish Provider Orientation in Articulate for Publication to Secure Provider Portal	100 days	Mon 08/08/16	Fri 12/23/16
290	Reformat Provider Orientation into word.doc for submission to State	100 days	Mon 08/08/16	Fri 12/23/16
291	Submit training materials to State for approval	78 days	Mon 09/12/16	Wed 12/28/16
292	Edit/revise Provider Orientation to better meet state requirements	55 days	Mon 10/10/16	Fri 12/23/16
293	Obtain State approval	45 days	Mon 10/31/16	Fri 12/30/16
294	Submit to Digital Communications for upload to Secure Provider Portal	55 days	Mon 10/17/16	Fri 12/30/16
295	Create and submit web-message and attestation to Digital Communications	54 days	Mon 10/17/16	Thu 12/29/16
296	**Communications**	**150 days**	**Mon 06/06/16**	**Fri 12/30/16**
297	**Member and Provider Communications**	**125 days**	**Mon 07/11/16**	**Fri 12/30/16**
298	Submit draft Member Handbook and ID card template to RA	55 days	Mon 08/08/16	Fri 10/21/16
299	Submit draft Provider Manual to RA	55 days	Mon 08/08/16	Fri 10/21/16
300	Submit Member and Provider Communications P & Ps	55 days	Mon 07/11/16	Fri 09/23/16
301	Provide required member and provider materials list to PMO	20 days	Mon 08/08/16	Fri 09/02/16
302	Address MLTC' changes to the member handbook and upload to RA for resubmission	36 days	Mon 10/10/16	Mon 11/28/16
303	Address MLTC' changes to the provider manual and upload to RA for resubmission	36 days	Mon 10/10/16	Mon 11/28/16
304	Upload all operational member-facing materials to RA for review prior to MLTC submission	58 days	Mon 09/05/16	Wed 11/23/16
305	Address MLTC's changes to the member handbook and upload to RA for resubmission (multiple rounds)	54 days	Mon 10/10/16	Thu 12/22/16
306	Address MLTC's changes to the provider manual and upload to RA for resubmission (multiple rounds)	54 days	Mon 10/10/16	Thu 12/22/16

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ID	Task Name	Duration	Start	Finish
307	Complete assigned C360 assessments	58 days	Mon 08/15/16	Wed 11/02/16
308	Update all member materials and upload to RA for resubmission	4 days	Mon 10/10/16	Thu 10/13/16
309	Revise the ID card and HOH kit BRDs and obtain internal approvals	75 days	Mon 09/12/16	Fri 12/23/16
310	Receive test files from IT and provide to the print vendor	10 days	Mon 10/24/16	Fri 11/04/16
311	Post the final, approved provider manual to the Nebraska website	50 days	Mon 10/24/16	Fri 12/30/16
312	Ensure alternative formats are available	70 days	Mon 09/19/16	Fri 12/23/16
313	Complete member handbook translations and upload to RA for MLTC submission	54 days	Mon 10/17/16	Thu 12/29/16
314	Complete UAT sign-off of ID card and HOH kit testing	45 days	Mon 10/17/16	Fri 12/16/16
315	Production release for ID cards and HOH kits	45 days	Mon 10/17/16	Fri 12/16/16
316	Mail ID cards to members within 5 days of receipt of eligibility file	20 days	Mon 12/05/16	Fri 12/30/16
317	Mail HOH kits to members within 5 days of receipt of eligibility file	20 days	Mon 12/05/16	Fri 12/30/16
318	**Materials and Communication**	**27 days**	**Mon 08/15/16**	**Tue 09/20/16**
319	Ensure benefit are listed in Member/Provider Materials	4 days	Mon 08/15/16	Thu 08/18/16
320	Quality (QA) Review of Member Materials	5 days	Mon 08/22/16	Fri 08/26/16
321	Submit Benefits for the Web	4 days	Mon 08/22/16	Thu 08/25/16
322	Perform QA review of Website	2 days	Mon 08/29/16	Tue 08/30/16
323	Provide Production Implementation Approval	2 days	Mon 09/05/16	Tue 09/06/16
324	Submit to RA for state submission	1 day	Wed 09/07/16	Wed 09/07/16
325	Cultural Competency plan	1 day	Mon 09/12/16	Mon 09/12/16
326	Complete mini Marketing Booklet draft and submit to MarComm	5 days	Wed 09/14/16	Tue 09/20/16
327	**Electronic Communication**	**130 days**	**Mon 06/27/16**	**Fri 12/23/16**
328	Create mechanism to collect info on member's preferred mode/format	130 days	Mon 06/27/16	Fri 12/23/16
329	Ensure no confidential emails	130 days	Mon 06/27/16	Fri 12/23/16
330	**Undeliverable email notice via USPS**	**75 days**	**Mon 09/12/16**	**Fri 12/23/16**
331	Write undeliverable email notice	40 days	Mon 09/12/16	Fri 11/04/16
332	Send to MLTC for approval	50 days	Mon 10/17/16	Fri 12/23/16
333	Ensure vendor can mail	59 days	Mon 10/03/16	Thu 12/22/16
334	**Develop ability to receive electronic communication from members**	**145 days**	**Mon 06/13/16**	**Fri 12/30/16**
335	Email	145 days	Mon 06/13/16	Fri 12/30/16
336	Member website	135 days	Mon 06/20/16	Fri 12/23/16
337	Ability to respond to electronic inquiries in 1 business day	135 days	Mon 06/20/16	Fri 12/23/16

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ID	Task Name	Duration	Start	Finish
338	**Digital Communications (M=Member; P=Provider)**	**150 days**	**Mon 06/06/16**	**Fri 12/30/16**
339	Create website - Member and Provider (M/P) - Member site includes Find a Provider tool and provider quality information	150 days	Mon 06/06/16	Fri 12/30/16
340	**Market Office**	**85 days**	**Mon 09/05/16**	**Fri 12/30/16**
341	Market Regulatory Affairs	85 days	Mon 09/05/16	Fri 12/30/16
342	Approve contract deliverables and send to MLTC for approval	85 days	Mon 09/05/16	Fri 12/30/16
343	**Submit marketing materials**	**85 days**	**Mon 09/05/16**	**Fri 12/30/16**
344	Mail	63 days	Mon 10/03/16	Wed 12/28/16
345	Radio	63 days	Mon 10/03/16	Wed 12/28/16
346	Television	63 days	Mon 10/03/16	Wed 12/28/16
347	billboards	63 days	Mon 10/03/16	Wed 12/28/16
348	Participate in health fairs	63 days	Mon 10/03/16	Wed 12/28/16
349	Submit member materials to MLTC	56 days	Mon 10/10/16	Mon 12/26/16
350	Obtain approval of member materials from MLTC	64 days	Mon 10/03/16	Thu 12/29/16
351	Submit provider materials to MLTC	56 days	Mon 10/10/16	Mon 12/26/16
352	Obtain approval of provider materials from MLTC	65 days	Mon 10/03/16	Fri 12/30/16
353	P & Ps to ensure accuracy of regulatory reports	46 days	Mon 09/05/16	Mon 11/07/16
354	**Regulatory and Compliance**	**215 days**	**Mon 03/07/16**	**Fri 12/30/16**
355	**Policies and Procedures**	**158 days**	**Mon 05/09/16**	**Wed 12/14/16**
356	Review policies	25 days	Mon 05/09/16	Fri 06/10/16
357	Make required updates	70 days	Mon 06/06/16	Fri 09/09/16
358	Upload to 360 for regulatory review/approval	70 days	Mon 06/06/16	Fri 09/09/16
359	RA Review/Approval	45 days	Mon 08/01/16	Fri 09/30/16
360	1st Level Approver Review/Approver	30 days	Mon 09/05/16	Fri 10/14/16
361	Distribute to Impacted Departments once approved in 360	43 days	Mon 10/17/16	Wed 12/14/16
362	**Corporate Compliance**	**75 days**	**Mon 09/19/16**	**Fri 12/30/16**
363	Compliance Oversight Contract Breakdown	56 days	Mon 09/26/16	Mon 12/12/16
364	Market review	57 days	Mon 09/26/16	Tue 12/13/16
365	Breakdown Completion	75 days	Mon 09/19/16	Fri 12/30/16
366	Pre Go Live Assessment	57 days	Mon 10/10/16	Tue 12/27/16
367	Regulatory Reporting: Report Build and load to LIONS Deliverables	55 days	Mon 10/17/16	Fri 12/30/16
368	**Legal**	**63 days**	**Mon 09/05/16**	**Wed 11/30/16**
369	Submission of Vendor agreement to Nebraska RA	63 days	Mon 09/05/16	Wed 11/30/16

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ID	Task Name	Duration	Start	Finish
370	Submission of Provider template agreement(s) to Nebraska RA	63 days	Mon 09/05/16	Wed 11/30/16
371	Submission of Provider flow-downs to Nebraska RA	63 days	Mon 09/05/16	Wed 11/30/16
372	Submission of Vendor flow-downs to Nebraska RA	63 days	Mon 09/05/16	Wed 11/30/16
373	Submission of unilateral and bilateral amendments templates to market	63 days	Mon 09/05/16	Wed 11/30/16
374	**Human Resources**	**214 days**	**Mon 03/07/16**	**Thu 12/29/16**
375	**Develop staffing plan**	**214 days**	**Mon 03/07/16**	**Thu 12/29/16**
376	Recruit and hire Nebraska-based staff	204 days	Mon 03/07/16	Thu 12/15/16
377	Recruit and hire Corporate-based staff to support Nebraska market	208 days	Mon 03/07/16	Wed 12/21/16
378	Onboarding, new hire orientation and training	188 days	Mon 04/04/16	Wed 12/21/16
379	All Health Plan Personnel positions are fully staffed	43 days	Tue 11/01/16	Thu 12/29/16
380	**Enroll a Member**	**157 days**	**Mon 05/02/16**	**Tue 12/06/16**
381	**Enrollment**	**157 days**	**Mon 05/02/16**	**Tue 12/06/16**
382	Ensure data exchange with MLTC	75 days	Mon 06/06/16	Fri 09/16/16
383	Perform 834 File Processing (EES)	57 days	Mon 08/08/16	Tue 10/25/16
384	PCP Selection Testing	57 days	Mon 08/08/16	Tue 10/25/16
385	Membership Recon Reporting Testing	57 days	Mon 08/15/16	Tue 11/01/16
386	ID Card and Member Materials Fulfillment Testing	50 days	Mon 08/08/16	Fri 10/14/16
387	Create Data Quality Reports (Internal)	56 days	Wed 07/13/16	Wed 09/28/16
388	Regulatory Reporting	75 days	Tue 07/12/16	Mon 10/24/16
389	P & Ps	120 days	Mon 05/02/16	Fri 10/14/16
390	SATs & Curriculum Development	56 days	Mon 09/12/16	Mon 11/28/16
391	Training	57 days	Mon 09/19/16	Tue 12/06/16
392	Correspondences (Programmed into CTS; Tested)	75 days	Mon 07/04/16	Fri 10/14/16
393	Outbound 834 files to vendors	56 days	Mon 09/05/16	Mon 11/21/16
394	**Quality & Analytics**	**204 days**	**Mon 03/14/16**	**Thu 12/22/16**
395	Quality Management and Improvement Plan Draft	100 days	Mon 03/21/16	Fri 08/05/16
396	Policies and Procedures	95 days	Mon 05/02/16	Fri 09/09/16
397	Review/Approve Policies in C360	55 days	Mon 08/01/16	Fri 10/14/16
398	QAPI Program Documents	150 days	Fri 05/27/16	Thu 12/22/16
399	EPSDT Plan	150 days	Fri 05/27/16	Thu 12/22/16
400	Medical Records Standards	150 days	Fri 05/27/16	Thu 12/22/16
401	Performance improvement projects - PIP topic suggestions, PIP standards, proposed PIPs for the selected topics	150 days	Fri 05/27/16	Thu 12/22/16
402	Request for delegation of QAPI Program functions or activities (if applicable)	150 days	Fri 05/27/16	Thu 12/22/16

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
403	State Initiatives	135 days	Mon 03/14/16	Fri 09/16/16
404	**Utilization**	**100 days**	**Mon 05/09/16**	**Fri 09/23/16**
405	Utilization Management Program	100 days	Mon 05/09/16	Fri 09/23/16
406	**Finance**	**209 days**	**Mon 03/14/16**	**Thu 12/29/16**
407	**Build out new offices**	**205 days**	**Mon 03/14/16**	**Fri 12/23/16**
408	Identify cities	106 days	Mon 03/14/16	Mon 08/08/16
409	Identify office space	96 days	Fri 04/01/16	Fri 08/12/16
410	Lease office space	185 days	Mon 04/11/16	Fri 12/23/16
411	Determine number of staff for each	90 days	Mon 03/14/16	Fri 07/15/16
412	**Equipment**	**106 days**	**Mon 07/11/16**	**Mon 12/05/16**
413	Technology hardware and software	101 days	Mon 07/11/16	Mon 11/28/16
414	Telecom	101 days	Mon 07/11/16	Mon 11/28/16
415	Desks	101 days	Mon 07/18/16	Mon 12/05/16
416	**820 File**	**100 days**	**Mon 08/08/16**	**Fri 12/23/16**
417	IT processing of 820 to HTR	56 days	Mon 08/08/16	Mon 10/24/16
418	IT processing of 820 in HTR to EDW	94 days	Mon 08/15/16	Thu 12/22/16
419	Sign off of HTR 820 load to EDW	55 days	Mon 10/10/16	Fri 12/23/16
420	**Cash tie-out**	**166 days**	**Mon 05/09/16**	**Mon 12/26/16**
421	Treasury set up new bank account	56 days	Mon 05/09/16	Mon 07/25/16
422	Test Daily 820 Report	56 days	Mon 09/12/16	Mon 11/28/16
423	Sign off of cash tie-out	56 days	Mon 10/10/16	Mon 12/26/16
424	**Rate table**	**77 days**	**Mon 09/05/16**	**Tue 12/20/16**
425	Update rate determinant spreadsheet	56 days	Mon 09/05/16	Mon 11/21/16
426	IT populate rate table	56 days	Mon 09/05/16	Mon 11/21/16
427	Sign off of Rate Table	57 days	Mon 10/03/16	Tue 12/20/16
428	**Rates**	**56 days**	**Mon 09/05/16**	**Mon 11/21/16**
429	Send Rate Schedule to Actuary for review and approval	56 days	Mon 09/05/16	Mon 11/21/16
430	Upload rates	56 days	Mon 09/05/16	Mon 11/21/16
431	Run report showing rates	56 days	Mon 09/05/16	Mon 11/21/16
432	Sign off of rates uploaded	56 days	Mon 09/05/16	Mon 11/21/16
433	**Premium Reconciliation**	**82 days**	**Mon 09/05/16**	**Tue 12/27/16**
434	Identify state contact o help resolve remit discrepancies	56 days	Mon 09/05/16	Mon 11/21/16
435	Determine submission method for payment adjustments	57 days	Mon 10/10/16	Tue 12/27/16
436	**Analyst**	**56 days**	**Mon 09/12/16**	**Mon 11/28/16**
437	Identify analyst	56 days	Mon 09/12/16	Mon 11/28/16
438	Train analyst	56 days	Mon 09/12/16	Mon 11/28/16
439	**P & P**	**149 days**	**Mon 06/06/16**	**Thu 12/29/16**
440	Review RDP and contract for reconciliation requirements	56 days	Mon 06/06/16	Mon 08/22/16
441	Receive P & P approval from MLTC	50 days	Mon 10/17/16	Fri 12/23/16
442	Sign off by Premium Recon	45 days	Fri 10/28/16	Thu 12/29/16

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
443	**Accruals**	**56 days**	**Mon 09/19/16**	**Mon 12/05/16**
444	Set up new Revenue Summary Report	56 days	Mon 09/19/16	Mon 12/05/16
445	Add to Accrual Summary Report	56 days	Mon 09/19/16	Mon 12/05/16
446	Identify LOB-specific accruals	56 days	Mon 09/19/16	Mon 12/05/16
447	Sign off of Accruals	56 days	Mon 09/19/16	Mon 12/05/16
448	**Rev Recon Share Point**	**56 days**	**Mon 09/19/16**	**Mon 12/05/16**
449	Create new Share Point site	56 days	Mon 09/19/16	Mon 12/05/16
450	Link to Premium Reconciliation	56 days	Mon 09/19/16	Mon 12/05/16
451	Sign off of Rev Recon Share Point	56 days	Mon 09/19/16	Mon 12/05/16
452	**Information Technology (IT)**	**233 days**	**Mon 03/07/16**	**Wed 01/25/17**
453	**Specifications (M/P)**	**93 days**	**Tue 08/16/16**	**Thu 12/22/16**
454	Submit readiness review documents (M/P)	80 days	Tue 08/16/16	Mon 12/05/16
455	Readiness review (M/P)	54 days	Mon 10/10/16	Thu 12/22/16
456	State needs access to member and provider test environments (web demo)	54 days	Mon 10/10/16	Thu 12/22/16
457	**Content (M)**	**128 days**	**Tue 06/28/16**	**Thu 12/22/16**
458	Draft copy (M)	125 days	Tue 06/28/16	Mon 12/19/16
459	Submit copy for reading-level assessment (M)	125 days	Tue 06/28/16	Mon 12/19/16
460	Circulate copy for SME approval (M)	125 days	Tue 06/28/16	Mon 12/19/16
461	Submit copy to RA/state for review	101 days	Mon 07/11/16	Mon 11/28/16
462	Readiness Review - Web demo (M)	54 days	Mon 10/10/16	Thu 12/22/16
463	**Provider web updates (P)**	**43 days**	**Tue 11/01/16**	**Thu 12/29/16**
464	Post Provider Orientation module (P)	43 days	Tue 11/01/16	Thu 12/29/16
465	Post provider forms (as received) (P)	43 days	Tue 11/01/16	Thu 12/29/16
466	Post approved Provider Manual (P)	43 days	Tue 11/01/16	Thu 12/29/16
467	Post sample provider contract (P)	43 days	Tue 11/01/16	Thu 12/29/16
468	Post approved Nebraska Medicaid QRG to provider pages (P)	43 days	Tue 11/01/16	Thu 12/29/16
469	Post approved PDL to provider pages (P)	43 days	Tue 11/01/16	Thu 12/29/16
470	**Design (M)**	**95 days**	**Fri 07/29/16**	**Thu 12/08/16**
471	Submit request for images (M)	95 days	Fri 07/29/16	Thu 12/08/16
472	Images sent to IT (M)	95 days	Fri 07/29/16	Thu 12/08/16
473	**Provider secure portal updates (P)**	**78 days**	**Mon 06/06/16**	**Wed 09/21/16**
474	Implement Pharmacy Utilization	58 days	Mon 06/06/16	Wed 08/24/16
475	Implement electronic referral functionality, if required (P)	58 days	Mon 07/04/16	Wed 09/21/16
476	Provider materials posted (as received from business owners; includes forms)	58 days	Mon 07/04/16	Wed 09/21/16
477	Other provider website content updates (including posting updated PDF forms as received from business)	58 days	Mon 07/04/16	Wed 09/21/16
478	**IT Development**	**233 days**	**Mon 03/07/16**	**Wed 01/25/17**
479	Develop IT cost model	60 days	Mon 03/07/16	Fri 05/27/16
480	Develop Vision & Scope Document	60 days	Mon 03/07/16	Fri 05/27/16

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
481	Ensure Information Services requirements are in place to support program	205 days	Mon 03/21/16	Fri 12/30/16
482	Ensure capability of data exchange with MLTC	205 days	Mon 03/21/16	Fri 12/30/16
483	Release Management Plan Draft	1 day	Mon 06/20/16	Mon 06/20/16
484	System Problem Resolution Plan	1 day	Mon 06/20/16	Mon 06/20/16
485	**October Release**	**178 days**	**Mon 04/25/16**	**Wed 12/28/16**
486	BRD	90 days	Mon 04/25/16	Fri 08/26/16
487	FSD	75 days	Mon 05/23/16	Fri 09/02/16
488	Development	90 days	Mon 06/06/16	Fri 10/07/16
489	QA/UAT	79 days	Mon 06/27/16	Thu 10/13/16
490	Deploy	54 days	Sat 10/15/16	Wed 12/28/16
491	**December Release**	**148 days**	**Mon 06/06/16**	**Wed 12/28/16**
492	BRD	79 days	Mon 06/06/16	Thu 09/22/16
493	FSD	56 days	Mon 07/11/16	Mon 09/26/16
494	Development	79 days	Mon 08/08/16	Thu 11/24/16
495	QA/UAT	81 days	Mon 08/22/16	Mon 12/12/16
496	Deploy	9 days	Sat 12/17/16	Wed 12/28/16
497	**Disaster Recovery**	**103 days**	**Mon 09/05/16**	**Wed 01/25/17**
498	Backup plans and systems in place	44 days	Mon 10/24/16	Thu 12/22/16
499	Contingency and continuity planning	13 days	Mon 09/19/16	Wed 10/05/16
500	Continuity Plan	1 day	Wed 10/05/16	Wed 10/05/16
501	Delegation Oversight	93 days	Mon 09/19/16	Wed 01/25/17
502	Review delegation contracts and determine if any needed delegation actions	56 days	Mon 09/05/16	Mon 11/21/16
503	Validate that vendors are ready to use correct letter template	55 days	Mon 09/05/16	Fri 11/18/16
504	Post Go Live validation/audit of vendors' usage of correct letters	22 days	Mon 11/07/16	Tue 12/06/16
505	**Encounters**	**141 days**	**Mon 06/06/16**	**Mon 12/19/16**
506	Submission requirements and P & Ps	95 days	Mon 06/06/16	Fri 10/14/16
507	Confirm evaluation results with IT	45 days	Mon 08/22/16	Fri 10/21/16
508	IT testing	40 days	Mon 10/24/16	Fri 12/16/16
509	Encounters Claim Draft	1 day	Mon 12/19/16	Mon 12/19/16
510	**Integrated System Testing, if needed**	**76 days**	**Mon 08/01/16**	**Mon 11/14/16**
511	Process the 834 test files to load the membership into the system	55 days	Mon 08/01/16	Fri 10/14/16
512	Retrieve the paper claims from the FTP site and place them in a local folder	55 days	Mon 08/01/16	Fri 10/14/16
513	Load the paper claims from the state into Xcelys	76 days	Mon 08/01/16	Mon 11/14/16
514	Process the claim through the systems and into HTR	55 days	Mon 08/01/16	Fri 10/14/16
515	Move the claims from HTR to ER	55 days	Mon 08/01/16	Fri 10/14/16

Work Plan for Nebraska

ID	Task Name	Duration	Start	Finish
516	Create the 837 outbound test files	55 days	Mon 08/01/16	Fri 10/14/16
517	Verify the files and send them to the State	55 days	Mon 08/01/16	Fri 10/14/16
518	**Readiness Delivery**	**204 days**	**Mon 08/08/16**	**Thu 05/18/17**
519	**Onsite Readiness Review**	**130 days**	**Mon 08/08/16**	**Fri 02/03/17**
520	**Desk Audit**	**96 days**	**Mon 08/08/16**	**Mon 12/19/16**
521	Stage Material	56 days	Mon 08/08/16	Mon 10/24/16
522	Internal Reviews	56 days	Mon 10/03/16	Mon 12/19/16
523	Schedule Meeting with SMEs	56 days	Mon 10/03/16	Mon 12/19/16
524	Readiness Review Meeting	56 days	Mon 10/03/16	Mon 12/19/16
525	Document Corrective Actions	56 days	Mon 10/03/16	Mon 12/19/16
526	**Onsite visit**	**85 days**	**Mon 10/10/16**	**Fri 02/03/17**
527	Schedule meeting with SMEs	57 days	Mon 10/10/16	Tue 12/27/16
528	Stage material	57 days	Mon 10/10/16	Tue 12/27/16
529	Readiness planning	57 days	Mon 10/10/16	Tue 12/27/16
530	Readiness rehearsal	40 days	Mon 10/17/16	Fri 12/09/16
531	Readiness Review with MLTC	55 days	Mon 10/17/16	Fri 12/30/16
532	Portal demo	44 days	Mon 10/17/16	Thu 12/15/16
533	Document Corrective Actions	40 days	Mon 10/24/16	Fri 12/16/16
534	Implement Corrective Actions	75 days	Mon 10/24/16	Fri 02/03/17
535	**Go-Live Launch**	**58 days**	**Mon 12/19/16**	**Wed 03/08/17**
536	**Pre-Launch**	**58 days**	**Mon 12/19/16**	**Wed 03/08/17**
537	Final pre-launch readiness checkpoint	58 days	Mon 12/19/16	Wed 03/08/17
538	**Program Launch**	**0 days**	**Sun 01/01/17**	**Sun 01/01/17**
539	Program Go Live	0 days	Sun 01/01/17	Sun 01/01/17
540	**Post Go Live Monitoring**	**99 days**	**Mon 01/02/17**	**Thu 05/18/17**
541	Daily Post Go Live Meetings	98 days	Mon 01/02/17	Wed 05/17/17
542	Monitor Customer Service performance metrics	54 days	Mon 01/02/17	Thu 03/16/17
543	Monitor for member/provider abrasion	54 days	Mon 01/02/17	Thu 03/16/17
544	30-day monitoring	54 days	Mon 01/02/17	Thu 03/16/17
545	Lessons Learned	56 days	Tue 01/31/17	Tue 04/18/17
546	Extended Post Go Live monitoring for outstanding IT items	99 days	Mon 01/02/17	Thu 05/18/17
547	Project Close-Out	0 days	Thu 05/18/17	Thu 05/18/17

ATTACHMENT 5

6. Draft Member Handbook - Submit a draft copy of the member handbook as described in Section IV.F – Member Services and Education.

Please see Draft Member Handbook attached herein.

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWELVE

Date: December 30, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened January 5, 2016 at 2:00 p.m. Central Time

The State does not anticipate posting additional amendments and/or addendums.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Attachment 40 - Updated MLR and Risk Corridor Examples

Example 1. MCO pays money back to State under MLR and risk corridor

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	3,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	80,500
Net Qualified Medical Expenses divided by Earned Revenue		80.4%
Minimum MLR %		85.0%
Percentage below MLR		4.6%
MLR Reconciliation Payment	**$**	**(4,555)**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	(4,555)
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,500
Total Activities that Improve Health Care Quality	$	3,000
Allowed Activities that Improve Health Care Quality	$	3,000
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Administration (QI and non-QI)	$	10,000
Profit/(Loss)	$	8,010
Risk Corridor Profit/(Loss) Share	**$**	**(5,008)**

Example 2. State pays money back to MCO under risk corridor

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	3,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	110,500
Net Qualified Medical Expenses divided by Earned Revenue		110.4%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,500
Total Activities that Improve Health Care Quality	$	3,000
Allowed Activities that Improve Health Care Quality	$	3,000
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,000
Total Administration (QI and non-QI)	$	10,000
Profit/(Loss)	$	(17,435)
Risk Corridor Profit/(Loss) Share	**$**	**14,433**

Example 3. Administrative expenses exceed admin cap

Earned Revenue for MLR/Risk Corridor		
Gross Capitation Payment	$	105.54
HIT	$	3.69
Hold-Back	$	1.53
Performance Penalty	$	0.25
Net Capitation Payment for MLR/Risk Corridor	$	100.06
MMs		1,000
Earned Revenue for MLR/Risk Corridor	**$**	**100,065**

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	4,000
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	111,500
Net Qualified Medical Expenses divided by Earned Revenue		111.4%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back, performance penalty, and HIT)	$	100,065
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,500
Total Activities that Improve Health Care Quality	$	4,000
Allowed Activities that Improve Health Care Quality	$	3,002
Total Incurred Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	12,000
Total Allowed Administration (Excluding HIT, hold-back, performance penalty, and QI)	$	7,005
Total Administration (QI and non-QI)	$	10,006
Profit/(Loss)	$	(17,442)
Risk Corridor Profit/(Loss) Share	**$**	**14,440**

Addendum 11 – Additional Revisions to RFP

Document	Section	Change From:	Change to:
RFP	IV.H.4.b	The member or provider may file an appeal within 90 calendar days from the date on the MCO's Notice of Action.	The member or provider may file an MCO-level appeal within a timeframe that is not less than 20 calendar days and not more than 90 calendar calendar days from the date on the MCO's Notice of Action.
RFP	IV.H.7.c	The member or the member's representative (if any) may request a state fair hearing within 90 calendar days from the date of the MCO Notice of Action.	The member or the member's representative (if any) may request a state fair hearing within a timeframe that is not less than 20 calendar days and not more than 90 calendar days from the date of the MCO's notice of resolution.
Addendum 6	Q. 112	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region.	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 227	The MLTC Quality Performance hold-back is not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back is factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute. The State Performance Penalty is included in the minimum MLR, risk corridor, and the Administrative Cap.	The MLTC Quality Performance hold-back and the State Performance Penalty (SPP) are not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back and SPP are factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute.
Addendum 7	Q. 230	In terms of the actuarial certification, only the MLTC Quality Performance hold-back is considered a withhold.	Yes, both the MLTC Quality Performance hold-back and State Performance Penalties will be considered withholds in the actuarial certification.

Addendum 7	Q. 249	See Attachment 21: "Non-Medical Load Assumptions". NML is based on the experience of current Managed Care Entities.	See Attachment 21: "Non-Medical Load Assumptions". NML is based on the experience of current Managed Care Entities. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 254	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties is considered a component of non-medical load and is added in along with other administrative funding.	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties was originally considered a component of non-medical load and was added in along with other administrative funding. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 7	Q. 341	See response to Question #33.	Yes, both the MLTC Quality Performance Program and the State Performance Penalty are excluded from the revenue calculation of the risk corridor. Please see Attachment 40 for an example of the exclusion.

Addendum 9	Q. 67	This information will be posted to the procurement website no later than December 24, 2015.	The risk corridor calculation formula in Section IV.P.9.c is amended as follows: “Risk corridor profit/loss = qualifying revenue -MLR rebate -Net qualified medical expenses calculated for the risk corridor -Total allowed administration calculated for the administrative cap” This indicates that activities to improve health care quality may be considered a medical expense for the MLR calculation but will be considered an administrative expense for the risk corridor calculation. Activities to improve healthcare quality should be reported under the total allowed administration calculated for the administrative cap, under the risk corridor calculation. Please see Attachment 40.
Addendum 9	Q. 68	This information will be posted to the procurement website no later than December 24, 2015.	1. The UNMC portion of the revenue and expenses will be included in the MLR and Risk Corridor calculations. 2. The earned revenue used in the MLR and Risk Corridor calculations should exclude the QPP hold-back. As such, both the earned and unearned portions of the 1.5% hold-back are excluded from the calculations. 3. The earned and unearned portion of the 0.25% Performance Penalty are excluded from the risk corridor and MLR calculations. Please see Attachment 40.
Addendum 9	Q. 69	This information will be posted to the procurement website no later than December 24, 2015.	Please see Attachment 40.
Addendum 9	Q. 70	This information will be posted to the procurement website no later than December 24, 2015.	Please see Attachment 40.

Addendum 9	Q. 72	All items on this list will be considered in the rate certification in the Spring of 2016. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, the State's actuaries anticipate using additional runout from FFS data and current Managed Care entities. No changes to the base period are anticipated.	All items on this list are aspects of rate setting that will be revisited in the Spring. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, Optumas anticipates using additional runout from FFS data and current Managed Care entities. As part of receiving the updated data extracts the rate setting process will be revisited, but at this time it is not anticipated that a new base period will be used. Currently, the 0.25% State Performance Penalty is loaded in to the rate as an at-risk incentive. When final rates are developed in early 2016, the 0.25% will be treated as a withhold and handled identically to the 1.5% Quality Performance Program. It will no longer be a component of non-medical loading.
Addendum 9	Q. 74	This information will be posted to the procurement site no later than December 24, 2015.	1) and 2): Hepatitis C expenditures occur in two aid categories in Rating Region 1 and two categories in Rating Region 2. In Rating Region 1, the AABD 21+ M&F cohort has a Hepatitis C PMPM of $18.55 and a non-Hepatitis C PMPM of $356.37. The Family 21+ M&F cohort has a Hepatitis C PMPM of $1.22 and a non-Hepatitis C PMPM of $76.12. In Rating Region 2 the AABD 21+ M&F cohort has a Hepatitis C PMPM of $25.14 and a non-Hepatitis C PMPM of $439.50, and the Non-Dual Waiver cohort has a Hepatitis C PMPM of $17.66 and a non-Hepatitis C PMPM of $360.20. 3) This information is not available.

Attachment 39
Revised Access Standards

Appointment Availability Access Standards

1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.

3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.

4. Family planning services must be available within seven calendar days.

5. Non-urgent, preventive care must be available within 4 weeks.

6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

Geographic Access Standards

1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members 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.

2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.

3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.

    a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences.

    b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences.

    c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.

4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.

5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census.

7. The MCO must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 37 - Delivery Costs by COA

	Rating Region 1			Rating Region 2		
Original COA	**Deliveries**	**Expenditures**	**Per Delivery**	**Deliveries**	**Expenditures**	**Per Delivery**
AABD 00-20 M&F	15	$ 112,062	$ 7,670	1	$ 5,986	$ 5,986
AABD 21+ M&F	106	$ 1,321,111	$ 12,423	21	$ 196,934	$ 9,433
AABD 21+ M&F-WWC	-	$ -	$ -	-	$ -	$ -
CHIP M&F	36	$ 264,095	$ 7,285	18	$ 112,076	$ 6,260
Family Under 1 M&F	-	$ -	$ -	-	$ -	$ -
Family 01-05 M&F	-	$ -	$ -	-	$ -	$ -
Family 06-20 F	1,072	$ 7,005,438	$ 6,535	399	$ 2,539,328	$ 6,364
Family 06-20 M	1	$ 6,064	$ 6,064	-	$ -	$ -
Family 21+ M&F	5,392	$ 35,796,353	$ 6,639	1,769	$ 11,676,614	$ 6,599
Foster Care M&F	26	$ 181,510	$ 6,901	3	$ 18,390	$ 6,130
Katie Beckett 00-18 M&F	-	$ -	$ -	-	$ -	$ -
Maternity	-	$ -	$ -	-	$ -	$ -
Claims/Encounters Total	6,649	$ 44,686,633	$ 6,721	2,211	$ 14,549,328	$ 6,580
Supplemental/Subcap Payments		$ 885,608			$ 217,203	
Total	6,649	$ 45,572,242	$ 6,854	2,211	$ 14,766,531	$ 6,678
Databook Total	6,649	$ 45,572,242	$ 6,854	2,211	$ 14,766,531	$ 6,678
Difference	-	$ -	$ -	-	$ -	$ -

Attachment 36 - COA Crosswalk

Rating Cohort	COA
AABD 00-20 M&F	AABD
AABD Under 1 M&F	AABD
AABD 01-20 M&F	AABD
AABD 21+ M&F	AABD
AABD 21+ M&F-WWC	AABD
CHIP Under 1 M&F	CHIP
CHIP 01-19 M&F	CHIP
CHIP M&F	CHIP
Family Under 1 M&F	Family
Family 01-05 M&F	Family
Family 06-20 F	Family
Family 06-20 M	Family
Family 21+ M&F	Family
Foster Care Under 1 M&F	Foster Care
Foster Care 01-19 M&F	Foster Care
Foster Care M&F-SA	Foster Care
Foster Care M&F	Foster Care
Maternity	Maternity
Katie Beckett 00-18 M&F	AABD

Rating Region 1

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 00-20 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.4%
AABD 00-20 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.9%
AABD 00-20 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	9.5%
AABD 00-20 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	3.7%
AABD 00-20 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	597.6%	-18.2%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.3%	0.2%
AABD 00-20 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 00-20 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.0%	0.0%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
AABD 00-20 M&F	Behavioral Health - OP	71.7%	0.0%	43.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	9.2%
AABD 00-20 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
AABD 00-20 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%
AABD 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.8%
AABD 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	17.7%
AABD 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-2.1%
AABD 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	350.5%	-21.5%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.3%	-0.1%
AABD 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.2%
AABD 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.1%	-0.7%
AABD 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 21+ M&F-WWC	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%
AABD 21+ M&F-WWC	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.7%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F-WWC	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.3%
AABD 21+ M&F-WWC	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F-WWC	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%
CHIP M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.0%
CHIP M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.4%
CHIP M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	10.7%
CHIP M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-0.1%
CHIP M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	254.2%	-30.6%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-1.0%	0.6%
CHIP M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.4%	0.0%	0.0%	0.0%	0.0%
CHIP M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
CHIP M&F	Behavioral Health - OP	11.1%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	10.3%
CHIP M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	34.8%
CHIP M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.6%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family Under 1 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	1.5%
Family Under 1 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	10.3%
Family Under 1 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.7%
Family Under 1 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	316.7%	-42.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	-0.5%	0.3%
Family Under 1 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-4.2%	0.0%	0.0%	0.0%	0.0%
Family Under 1 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family Under 1 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.1%
Family 01-05 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.9%
Family 01-05 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	5.1%
Family 01-05 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	300.8%	-42.1%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.6%	0.4%
Family 01-05 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-3.0%	0.0%	0.0%	0.0%	0.0%
Family 01-05 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.7%
Family 01-05 M&F	Behavioral Health - OP	82.2%	0.0%	9.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.1%
Family 01-05 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 06-20 F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	3.1%
Family 06-20 F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.8%
Family 06-20 F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.8%
Family 06-20 F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-1.5%
Family 06-20 F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	281.9%	-18.9%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-1.2%	0.6%
Family 06-20 F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.8%	0.0%	0.0%	0.0%	0.0%
Family 06-20 F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 F	Behavioral Health - OP	5.7%	0.0%	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.7%
Family 06-20 F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	34.0%
Family 06-20 F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Family 06-20 M	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.9%
Family 06-20 M	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	27.2%
Family 06-20 M	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	11.9%
Family 06-20 M	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.2%
Family 06-20 M	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	416.0%	-26.5%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.3%	0.2%
Family 06-20 M	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
Family 06-20 M	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 M	Behavioral Health - OP	4.8%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.4%
Family 06-20 M	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	22.0%
Family 06-20 M	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%
Family 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	13.0%
Family 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.4%
Family 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	310.1%	-18.7%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.4%
Family 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.4%	-0.1%
Family 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.2%
Family 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.2%
Family 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.8%
Family 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.5%	0.0%	0.0%	0.0%	0.0%
Family 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.7%
Family 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Family 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.8%
Foster Care M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.5%
Foster Care M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	6.7%
Foster Care M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	-1.0%
Foster Care M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	97.0%	-10.3%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	-0.1%	0.1%
Foster Care M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
Foster Care M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	Behavioral Health - OP	14.0%	0.0%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Foster Care M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	22.7%
Foster Care M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Katie Beckett 00-18 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-2.4%
Katie Beckett 00-18 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.7%	0.0%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - OP	9373.3%	0.0%	59.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%
Katie Beckett 00-18 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Maternity	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	1.8%
Maternity	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.1%
Maternity	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	16.7%
Maternity	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.2%
Maternity	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	116.8%	12.4%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-0.5%	0.4%
Maternity	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	-0.7%
Maternity	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Rating Region 2											
		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 00-20 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.2%
AABD 00-20 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.3%
AABD 00-20 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.0%
AABD 00-20 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	1.1%
AABD 00-20 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	15.4%	-8.5%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.4%	0.2%
AABD 00-20 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 00-20 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.6%	0.0%	0.0%	0.0%	0.0%
AABD 00-20 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
AABD 00-20 M&F	Behavioral Health - OP	46.4%	0.0%	34.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	9.1%
AABD 00-20 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 00-20 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
AABD 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.6%
AABD 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	3.8%
AABD 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.7%
AABD 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	65.6%	-13.0%	0.3%	0.0%	0.0%	0.0%
AABD 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.2%	0.0%
AABD 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	-0.1%
AABD 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	-0.2%	-0.7%
AABD 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
AABD 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
AABD 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
AABD 21+ M&F-WWC	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	69.7%	-20.7%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.3%	0.0%	0.0%	0.0%	0.0%
AABD 21+ M&F-WWC	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 21+ M&F-WWC	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.5%
AABD 21+ M&F-WWC	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
AABD 21+ M&F-WWC	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
CHIP M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.3%
CHIP M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.1%
CHIP M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.2%
CHIP M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	-3.0%
CHIP M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	187.6%	-35.2%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.4%	0.2%
CHIP M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
CHIP M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	0.0%	0.0%	0.0%	0.0%
CHIP M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
CHIP M&F	Behavioral Health - OP	9.1%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	10.4%
CHIP M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.1%
CHIP M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family Under 1 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.3%
Family Under 1 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	1.4%
Family Under 1 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.2%
Family Under 1 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	189.8%	-48.8%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.0%
Family Under 1 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-4.1%	0.0%	0.0%	0.0%	0.0%
Family Under 1 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.1%
Family Under 1 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family Under 1 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.5%
Family 01-05 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.5%
Family 01-05 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	2.8%
Family 01-05 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	243.1%	-31.2%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.2%	0.1%
Family 01-05 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 01-05 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-2.6%	0.0%	0.0%	0.0%	0.0%
Family 01-05 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - OP	94.0%	0.0%	10.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.2%
Family 01-05 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Family 01-05 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 06-20 F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.6%
Family 06-20 F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.5%
Family 06-20 F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.6%
Family 06-20 F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	3.6%
Family 06-20 F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	117.7%	43.9%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.6%	0.3%
Family 06-20 F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.5%	0.0%	0.0%	0.0%	0.0%
Family 06-20 F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 F	Behavioral Health - OP	4.2%	0.0%	6.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	9.6%
Family 06-20 F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	35.9%
Family 06-20 F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.2%
Family 06-20 M	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.6%
Family 06-20 M	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	1.4%
Family 06-20 M	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	7.5%
Family 06-20 M	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	495.1%	-46.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	-0.4%	0.2%
Family 06-20 M	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Family 06-20 M	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.0%	0.0%	0.0%	0.0%	0.0%
Family 06-20 M	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 06-20 M	Behavioral Health - OP	3.8%	0.0%	6.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	9.4%
Family 06-20 M	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.4%
Family 06-20 M	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Family 21+ M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.2%
Family 21+ M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	2.7%
Family 21+ M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.4%
Family 21+ M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	212.8%	-37.1%	0.2%	0.0%	0.0%	0.0%
Family 21+ M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.3%
Family 21+ M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.5%	0.2%
Family 21+ M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-0.1%
Family 21+ M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-0.3%	-0.9%
Family 21+ M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.6%	0.0%	0.0%	0.0%	0.0%
Family 21+ M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.9%
Family 21+ M&F	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.8%
Family 21+ M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Family 21+ M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.4%
Foster Care M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.2%
Foster Care M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	1.0%
Foster Care M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	5.0%
Foster Care M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	122.5%	-46.5%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Foster Care M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-0.7%	0.0%	0.0%	0.0%	0.0%
Foster Care M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Foster Care M&F	Behavioral Health - OP	12.7%	0.0%	8.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Foster Care M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	18.9%
Foster Care M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%

		ASD Addition		DD Addition		Service Delivery Adjustme		Immediate Enrollment		Program Changes	
COA	COS	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact	Util. Impact	UC Impact
Katie Beckett 00-18 M&F	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	-2.4%
Katie Beckett 00-18 M&F	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%	0.0%	0.0%	0.0%	0.0%
Katie Beckett 00-18 M&F	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - OP	9373.3%	0.0%	59.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%
Katie Beckett 00-18 M&F	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Katie Beckett 00-18 M&F	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Maternity	DME/Supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Room	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Emergency Transportation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	EPSDT	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Family Planning	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.1%
Maternity	FQHC/RHC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	11.0%
Maternity	Home Health	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Inpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.5%
Maternity	Lab and Radiology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Non-Emergency Transportation - Ambulance	0.0%	0.0%	0.0%	0.0%	363.3%	-24.8%	1.8%	0.0%	0.0%	0.0%
Maternity	Other Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	-0.1%
Maternity	Other Professional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-1.2%	0.9%
Maternity	Outpatient Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	PCP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Specialist	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.0%
Maternity	Vision	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	-0.6%	-0.3%
Maternity	Rx	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - IP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - OP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Residential	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity	Behavioral Health - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Attachment 34 - Rate Adjustment Crosswalk

Attachment 20	Attachment 22
ASD Adjustment	ASD Adjustment
DD Adjustment	DD Adjustment
Service Delivery Adjustments	Service Delivery Adjustment
Immediate Enrollment	Immediate Enrollment
APR-DRG	Policy Changes
FQHC Rate Updates	Policy Changes
Prospective Behavioral Health Provider Increase	Policy Changes
PRTF Program Change	Policy Changes
MST/FFT Carve-In	Policy Changes
Behavioral Health Copay Adjustment	Policy Changes
Physical Health Copay Adjustment	Policy Changes
Benefit Limits	Policy Changes

Heritage Health:

Est Ave Monthly Medicaid Eligibles Remaining FFS *(based on SFY2015)*

County	County Code	Ave Monthly
Adams	01	**96**
Antelope	02	**18**
Arthur	03	**1**
Banner	04	**1**
Blaine	05	**1**
Boone	06	**15**
Box Butte	07	**37**
Boyd	08	**9**
Brown	09	**8**
Buffalo	10	**106**
Burt	11	**24**
Butler	12	**12**
Cass	13	**45**
Cedar	14	**21**
Chase	15	**8**
Cherry	16	**9**
Cheyenne	17	**29**
Clay	18	**18**
Colfax	19	**22**
Cuming	20	**23**
Custer	21	**28**
Dakota	22	**57**
Dawes	23	**20**
Dawson	24	**81**
Deuel	25	**7**
Dixon	26	**12**
Dodge	27	**139**
Douglas	28	**1,362**
Dundy	29	**7**
Fillmore	30	**12**
Franklin	31	**10**
Frontier	32	**3**
Furnas	33	**12**
Gage	34	**67**
Garden	35	**8**
Garfield	36	**8**
Gosper	37	**4**
Grant	38	**2**
Greeley	39	**3**
Hall	40	**154**
Hamilton	41	**17**
Harlan	42	**7**
Hitchcock	44	**12**
Holt	45	**28**
Hooker	46	**4**
Howard	47	**13**

County	County Code	Ave Monthly
Jefferson	48	**20**
Johnson	49	**8**
Kearney	50	**16**
Keith	51	**35**
Kimball	53	**14**
Knox	54	**21**
Lancaster	55	**561**
Lincoln	56	**116**
Logan	57	**2**
Loup	58	**2**
Madison	59	**131**
McPherson	60	**1**
Merrick	61	**26**
Morrill	62	**13**
Nance	63	**19**
Nemaha	64	**18**
Nuckolls	65	**16**
Otoe	66	**38**
Pawnee	67	**10**
Perkins	68	**4**
Phelps	69	**24**
Pierce	70	**13**
Platte	71	**61**
Polk	72	**14**
Red Willow	73	**28**
Richardson	74	**31**
Rock	75	**8**
Saline	76	**36**
Sarpy	77	**226**
Saunders	78	**54**
Scotts Bluff	79	**115**
Seward	80	**37**
Sheridan	81	**12**
Sherman	82	**10**
Sioux	83	**1**
Stanton	84	**10**
Thayer	85	**19**
Thomas	86	**6**
Thurston	87	**39**
Valley	88	**7**
Washington	89	**32**
Wayne	90	**17**
Webster	91	**18**
York	93	**38**
Out of State	00	**767**
	99	**85**

Total Ave Mo		**2,579**

Attachment 32, Nebraska Medicaid Eligible Providers removed due to confidential information

2,160 pages

Addendum 10 – Additional Revisions to RFP

Document	Section	Change From:	Change to:
RFP	IV.D.3.j	All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff.	All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff, customer service representatives staffing the toll-free call center, and certain care management staff.
RFP	IV.E.14.a.iii	The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(a).	The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(c)(1)(ii)(A).
RFP	IV.I.12.d	Add new section	The MCO is prohibited from explicitly or implicitly communicating to potential network providers that the provider may face a lower reimbursement rate or any other financial or operational sanction should that provider choose not to sign a letter of intent with the MCO prior to the deadline for Heritage Health Proposals included in Addendum 8.
RFP	IV.N.4.d.vii	Use a licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.	Use a State-licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.
RFP	IV.N.10.a	Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative. If appropriate, the MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.	Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8. The MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.

RFP	IV.N.11.b	Restricted services are a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The restricted services mechanism cannot prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.	Restricted services are a mechanism for restricting Medicaid recipients to a specific hospital, primary care provider, prescribing provider, and/or a specific pharmacy provider in accordance with 471 NAC 2-004. The restricted services mechanism cannot prohibit the recipient from receiving services that meet the exceptions contained in 471 NAC 2-004.04.
RFP	IV.P.9.c	Risk corridor profit/loss = qualifying revenue - MLR rebate - Net qualified medical expenses calculated for the MLR - Total allowed administration calculated for the administrative cap.	Risk corridor profit/loss = qualifying revenue - MLR rebate - Net qualified medical expenses calculated for the risk corridor - Total allowed administration calculated for the administrative cap.
RFP	IV.Q.9.f	Add new section	If a MCO enters into a contract for the provision of services with a FQHC or RHC, the MCO shall provide payment that is not less than the level and amount of payment which the MCO would make for the services if the services were furnished by a provider which is not a FQHC or RHC.
RFP	Glossary of Terms	**Administrative expense rate:** The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that would have been incurred in the contract year in the absence of any related-party relationship.	**Administrative expense rate:** The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. These costs are subject to review to verify that the administrative services were actually provided and that the costs included for these services is reasonable. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party in connection with the administration of this contract will be included in such costs.

RFP	Glossary of Terms	**Patient-centered medical home (PCMH):** The Center for Medical Home Improvement defines PCMH as a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.	**Patient-centered medical home (PCMH):** A health care delivery model in which a patient establishes an ongoing relationship with a primary care practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.
RFP	Glossary of Terms	**Related-party administrative expense:** Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.	**Related-party administrative expense:** Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related-party for administrative costs actually incurred by the related party in connection with the administration of the contract.
Addendum 6	Question 69	MLTC will provide this answer in the second round of questions for this RFP.	No, Nebraska State-licensure is not required for all prior authorization and concurrent review staff. The prior authorization and concurrent review functions must meet the requirements of IV.D.3.a and IV.D.3.B regarding additional required staff. Nebraska State licensure is required for peer-to-peer consultations on prior authorizations and for adolescent psychiatrist review of prior authorization requests for psychotropic medication use in youth. Please see the amended IV.N.4.d.vii in this addendum.

Addendum 7	Question 247	As nearly all Medicaid eligible individuals will be included in Heritage Health, the State does not currently have an exact figure by county for the number of individuals that will continue to receive core benefits and services through the fee-for-service program. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see Attachment 33.
Addendum 7	Question 313	The State is reviewing this question further. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see revised definitions for **Administrative expense rate** and **Related-party administrative expense** in this Addendum.
Addendum 7	Question 332	A list of Medicaid-eligible providers will be posted on the procurement website as soon as it is available. This information will be posted to the procurement website as part of the second round of questions and answers.	Please see Attachment 32.
Attachment 4		As amended by Addendum 3: Revisions to RFP: Core Competency 1: Facilitate ongoing patient relationship with a primary care provider in a physician-directed team.	Core Competency 1: Facilitate ongoing patient relationship with a primary care practice team.
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: citalopram Recommended Max: 40mg/day	Generic Name: citalopram Recommended Max: 4-18 yrs – 40mg/day
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: paroxetine hcl Recommended Max: children – not recommended; 12-18 years – 40mg IR, 50mg CR	Generic Name: paroxetine hcl Recommended Max: children – not recommended; 13-18 years – 40mg IR, 50mg CR
Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: fluoxetine hcl (all oral) Recommended Max: 60mg/day	Generic Name: fluoxetine hcl (all oral) Recommended Max: 4-18 yrs - 60mg/day

Attachment 8	Table 2. Antidepressant High Dose Limit	Generic Name: sertraline hcl Recommended Max: 200mg/day	Generic Name: sertraline hcl Recommended Max: 4-18 yrs - 200mg/day

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM NINE
QUESTIONS and ANSWERS

Date: December 17, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened January 5, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			Considering that the Coalition for Community Pharmacy Action (CCPA)'s independent study of the cost to dispense based on 2013 data found the national cost of dispensing to be $10.55 and the cost of dispensing in Nebraska to be $10.62, what specific methodology was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify dispensing fees of $2.50 for chains and $4.45 for independents with less than six stores?	Please see response to Addendum 6, Question #37.
2.			What specific data-driven rationale and/or empirical research was cited in "discussions with the state and research of other states" (per answers to various Question 37 and others in Round 1) to justify differentiating dispensing fees for chain vs. independent pharmacies?	Please see response to Addendum 6, Question #37 for independent and non-independent pharmacy assumptions. For the purpose of capitation rate development for Heritage Health, the State's actuaries used the experience of another Midwestern state on its transition to a managed pharmacy benefit. This state experienced a significant drop in dispensing fees, below the fee used in the development of Heritage Health rates. This, along with discussion with Nebraska's pharmacy team served as the basis for adjusting non-independent pharmacy expenditures downward to account for lower dispensing fees.
3.			How will the Department ensure that pharmacies that do not fall under the category of an "independent pharmacy" will be paid dispensing fees	For nearly all other Heritage Health services, no rate floor exists. Reimbursement for pharmacy must consider both ingredient and dispensing fee components. Recognizing the unique nature of the pharmacy program MLTC has provided additional protections for pharmacy services, including

			that adequately cover their cost of dispensing?	requirements regarding timely updates to ingredient cost reimbursement and MAC transparency within the contract, as well as the minimum dispensing fee for smaller independent pharmacies. It is also important to note that network adequacy requirements exist to ensure that MCOs contract with a sufficient number of pharmacies based on their membership. MLTC will continue to evaluate these policies to ensure that recipients maintain adequate access to pharmacy services.
4.			Considering that when using cost as a determining factor for classifying specialty drugs, there is an increased risk that either some drugs will be inaccurately classified as specialty drugs, or others that are truly specialty drugs, will be inaccurately excluded, is the Department able to further revise the definition of the term "Specialty Drug" in the RFP?	The State does not intend to revise this term. Please see the Glossary of Terms for the definition of the term "Specialty Drug".
5.			Can you refer me to particular policymakers dedicated to the pharmacy-related provisions of the RFP?	Pharmacy-related provisions of the RFP were developed in conjunction with the MLTC Pharmacy Unit. Final decisions were made by MLTC leadership, including the Director and Deputy Directors. The MLTC organizational chart can be found at: http://dhhs.ne.gov/Org%20Charts/MLTC.pdf
6.	ATTACHEMENT 2 ACCESS STANDARDS		When looking at availability of Providers across both Regions we offer for your consideration as an indicator of access ONE PCP FTE per 10,000 population. This will ensure a more accurate picture as to the actual numbers of practicing and available Providers.	Access standards are set forth in Attachment 2.

7.	ATTACHEMENT 5 POLICIES, PROCEDURES AND PLANS		It is our understanding that "Letters of Intent" are not required as a part of the bidder's proposal. Is this true? If bidders make this request how should a provider respond?	A letter of intent from bidder(s) is not a requirement of the RFP. Please see Addendum 10.
8.	RFP SECTION Q PROJECT DESCRIPTION AND SCOPE	PAGE 149 PROVIDER REIMBURSEMENT	Will current Medicaid Rates be used to set the base rate for Provider Reimbursement? There is no mention or direction as to what will set the base rate for reimbursement. How will those base rates be determined if the Medicaid Rates are not used?	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP. The following sections of the RFP provide specific provider reimbursement requirements: IV.E.16 Family Planning Services IV.Q.4 Indian Health Protections IV.Q.5 Psychiatric Residential Treatment Facilities IV.Q.8. Payment to Out-of-Network Providers IV.Q.9 Reimbursement to FQHCs and RHCs IV.Q.14 Emergency Medical and Post-Stabilization Services IV.Q.16 Pharmacy Reimbursement
9.	Attachment 6/Attachment 19	N/A	Please clarify if the state is requesting samples of all reports in Attachment 6? Or only the 3 listed in Attachment 19, Question 115?	Bidders are required to provide examples of the reports listed in Attachment 19, Question 115. Bidders are not required to provide samples of reports listed in Attachment 6 unless otherwise required in the RFP, Attachments or Addendums.
10.	3. Technical Approach (b)	198	Please clarify if additional attachments allowed (in response to Attachment 19 questions)?	Attachments that are not specifically requested may not be considered in the evaluation process.
11.	Attachment 6	Pg 10	Please clarify if the reference to Section IV.O is a scrivener error? IV.O is not Provider Network.	Attachment 6 is hereby amended and superseded by Attachment 38. Please see Attachment 38.
12.	Attachment 2		Will MLTC be providing access standards for hospitals (non- behavioral health)?	Attachment 2 is hereby amended and superseded by Attachment 39. Please see Attachment 39.

13.	Attachment 6	Pg 1	If MLTC will require bidders to submit templates of all reports outlined in Attachment 6, will the MLTC template or MLTC approved format be provided to bidders for RFP submital?	Please see the response to Question #9 above.
14.	Attachment 2	Pg 2	Will zip code classification be allowed to demonstrate pharmacy access?	Pharmacy access must be demonstrated in accordance with Attachments 2 and 3.
15.	IV.D.3.a Additional Required Staff	50	Does the following requirement: "Prior authorization staff must include a State-licensed registered nurse or physician's assistant." apply to Pharmacy Prior Authorizations?	Please see Addendum 10.
16.	IV.D.3.j Additional Required Staff	51	We are prepared to locate Member Services functions locally in Nebraska as required on p. 50-51 of the RFP. For clarification, are Member Services functions required to be located in Nebraska inclusive of Customer Service Representatives who staff our toll-free call center?	Customer service representatives staffing the toll-free call center are not required to be located in the State. Please see Addendum 10.
17.	IV.E.11.c Nebraska Medicaid Preferred Drug List	59	Can the State provide the MLTC guidelines for off-label drug use or point to URL?	Guidelines are in accordance with Social Security Act 1927.[42 U.S.C 1396r-8] (g). https://www.ssa.gov/OP_Home/ssact/title19/1927.htm
18.	IV.E.11.c.ii Nebraska Medicaid Preferred Drug List	59	Can the State provide a current copy of the national drug code (NDC) file delegating the preferred or non-preferred status of each NDC?	Current PDL listing by therapeutic drug class can be found at: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

19.	IV.E.11.c.iii and c.v Nebraska Medicaid Preferred Drug List	59	On c.v. the timeframe appears to conflict with above 1 day requirement stated on c.iii: "The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes". Please provide further clarification.	The State will provide a biannual PDL file following review by the Pharmacy and Therapeutics Committee, as well as a weekly file with changes to the PDL. With respect to requirements for the weekly file, please see the response to Question #24-Addendum 6. Section IV.E.11.c.v refers to the biannual PDL file.
20.	IV.E.29 Excluded Services	67	Please clarify if state psychiatric hospitals fall under the definition of institutional care and whether services offered to Members in these institutions will be paid by MLTC on a FFS basis. In the event that a member enrolled in an MCO is admitted to a State psychiatric hospital, would the member be disenrolled from the MCO?	Services provided in State psychiatric hospitals are not excluded services per Section IV.E.29. A member would not be disenrolled as a result of an admission to a State psychiatric hospital. Per Section 1905(a) of the Social Security Act, federal financial participation is not available for Medicaid services provided to any individual under age 65 who is a patient in an institution for mental disease (IMD) unless the payment is for inpatient psychiatric services for individuals under age 21. Under this exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. Per Public Law 100-360, an IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in provided diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD exclusion applies only to institutions with at least 17 beds.
21.	IV.F. 14.d. Member Education	82	Please provide further clarity on Member Education Activities in Provider Offices, and, particularly, how these activities differ from Provider Marketing guidelines outlined in Section G(6)(f). For example, does the restriction against conducting member education in provider offices	The State hereby amends the RFP to remove Section IV.F.14.d on page 82. Providers may display MCO-provided health education materials consistent with the guidelines included in IV.G.6.f.ii. Providers may display MCO marketing materials consistent with requirements in IV.G.6.f.iii.

			apply only to non-existing members of the MCO? In addition, is MCO staff allowed to provide leave-behind branded educational materials (i.e. brochures, flyers) for the provider staff to display in the provider office?	
22.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the State provide clarification regarding its expectations of the provider advisory committee to "create network development and management strategies and procedures"?	The State anticipates that the provider advisory committee will provide MCOs with feedback on policies and procedures that will aid in addressing provider issues including but not limited to: service authorization, credentialing, care coordination, and claims adjudication. The MCO would consult with the provider advisory committee before making major decisions on policy changes regarding its network strategy whenever feasible, and would actively solicit feedback from the group on strategies to improve the administrative experience of network providers.
23.	IV.J.5.e Provider Outreach, Education, and Training	107	Can the behavioral health subcommittee be incorporated within the provider advisory committee (i.e. and not as a separate committee)?	The Behavioral Health Provider Advisory Committee may be considered a subcommittee of the Provider Advisory Committee so long as the Behavioral Health Provider Advisory Committee is comprised of behavioral health providers and providers knowledgeable about behavioral health related issues.
24.	IV.N.11.e.iv.a Restricted Services	132	RESTRICTED SERVICES (aka Pharmacy Lock-in): Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services. What if a member does not agree to Care Management, is this mandatory on the member?	Any member identified for care management activities must be offered care management services. In the case of an individual declining care management, the MCO must document this in the member's record. The MCO must still assign a care manager. The State requires the MCO to provide its proposed policies and procedures for applicable care management activities and any plan for ongoing communication with members who refuse care management.
25.	IV.N.11.e.i Restricted Services	132	"The MCO must be able to implement in it's claims system a restricted services	The State will provide information available in its MMIS for restricted services for each individual enrolled with a

			status for a member and have the ability to communicate this status to MLTC and other MCOs". Please clarify the Party that is sharing lock-in information when a member joins a plan: (A) Is it MLTC sending info on a FFS member only joining the plan? OR (B) Is it MLTC sending both FFS and/or another MCO member joining the plan? If the answer is "A", then is there any requirement for a member who transfers to another MCO? How would this occur?	MCO, including the type of restriction (any combination of pharmacy, primary care provider or hospital). This includes both individuals who have been fee for service and individuals who have been enrolled with another MCO. Restricted services transfer information occurs at the same time as the enrollment transfer and is reported in the supplemental enrollment file.
26.	IV.O.6.f Program Integrity – The MCO and MFPAU	136	The RFP states that "The MCO must subrogate to MFPAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products." Is the intent of this clause to encompass any and all potential subrogation claims, including but not limited to, claims where the MCO may be a member of a class action?	Yes, that is the intent of this requirement. Section IV.0.6.f is hereby amended as follows: “The MCO must subrogate to DHHS any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products."
27.	IV.Q.16.a Pharmacy Reimbursement	153	Can the State provide a list of independent pharmacies from MLTC with corresponding	The State cannot provide a list at this time. The State will provide this information to the awarded MCOs.

			pharmacy NPI? (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider?	
28.	IV.Q.16.c Pharmacy Reimbursement	153	"The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge." Please confirm that these are examples only and that we can reimburse at Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) methodology.	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by the State. A MCO must maintain in each paid claim record which methodology was used to determine final payment amounts. The approved methodologies include: State maximum allowable cost, national average drug acquisition cost or the submitted usual and customary charge. The State will allow other standard national drug pricing.
29.	IV.Q.17.f.iii Maximum Allowable Cost Program	153	"If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network." Does this requirement apply even if a pharmacy did not contest the MAC price?	If reimbursement rates are contested and as a result, are increased, this retroactive adjustment must be posted on the MCO's public website and available for all network pharmacies to reprocess claims retroactively.
30.	IV.S.4.h.ii Provider Identifier	166	"The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid." What about members traveling out of state in emergency situations? What about Rx's written in hospital Emergency	Please see Provider Bulletin 12-36: http://dhhs.ne.gov/medicaid/Documents/pb1236.pdf The State will provide a weekly Medicaid-enrolled provider file.

			departments? Please describe how an MCO can regularly receive an up-to-date listing of Medicaid providers so that this requirement can be met.	
31.	IV.X.7.b Transitioning from the MLTC FFS Pharmacy Program to the MCO Pharmacy Program	189	"The MCO must load to its pharmacy claims processing system the current prior authorization records from MLTC or its designee prior to the contract start date." Can the State provide a sample file layout and data dictionary to ensure all of the necessary elements are included (i.e. authorization start and end dates)? Would the MCO obtain all FFS Pharmacy claims information for members transferring from FFS? If a member is in a FFS Lock-in Program and transfers to the Plan, will the MCO get this information in the data file? Is the MCO expected to continue the lock-in?	The State is not able to provide a sample file layout and data dictionary as the State does not have this information. The fields may be developed in the spring with MMIS and shared with MCOs during readiness review. The State will provide the needed data to meet this requirement. The State will provide historical pharmacy claims available in its information system for each individual enrolled with the MCO, including fee-for-service claims. The State will also provide information on restricted services for each individual enrolled with the MCO, including the type of restriction (any combination of: pharmacy, hospital, or primary care provider). MCOs are required to use this information to continue restricted services. The MCO's restricted services policies and program must be in compliance with requirements in Section IV.N.11 Restricted Services, including but not limited to implementing a restriction program consistent with the provisions of 471 NAC 2. Per Attachment 5, the MCO must submit its proposed policies and procedures for approval of restricted services 45 days prior to the contract start date. This proposal must also include a procedure that verifies enrollees in a restricted status are able to access services provided by only approved providers by the contract start date.
32.	Capitation Rate Development - General	Attachments 20 and 23	The capitation rate development in Attachment shows annualized gross medical per member per month trends by rate cohort. Attachment 23 shows annualized medical expense trends by category of service (COS) by category of aid (COA). Please show a cross-walk of how trends by COA	No, the same COS trends were not applied to all rate cohorts within a given COA. Trend assumptions by COS and detailed rating cohort will be provided in early 2016. Please see Attachment 36 for a crosswalk of the rating cohorts into the broad COAs.

			and COS may be reconciled to develop and cross-check the final projected medical expense. Were the same COS trends applied to all rate cohorts within any given COA?	
33.	Capitation Rate Development - General	Attachments 20 and 23	Please show the separate cost and utilization components of the medical expense trends for COA and COS.	As outlined in the “NE – Heritage Health Second Bidder’s Conference Presentation – Optumas”, utilization trend and unit cost will be provided to awarded MCOs when the final rates are developed in early 2016.
34.	Amendment 6 Question #79	P.27 in the Amendment	Please provide further clarification the Amendment six answer to question 79: "MCOs may negotiate supplemental rebates for medications outside of the State’s PDL. MCOs are prohibited from negotiating supplemental rebates for any medications listed in the State’s PDL."Do the restriction on negotiating Supplemental rebates for PDL Drugs apply only to "Preferred Drugs"? or to both Preferred and Non-Preferred PDL Drugs?	Covered outpatient drugs include drugs on the Nebraska Medicaid PDL (preferred and non-preferred) and drugs not on the PDL. The PDL consists of drugs within multiple therapeutic drug classes. The MCO may not negotiate supplemental rebates for preferred or non-preferred drugs within the PDL therapeutic drug classes covered by the Nebraska Medicaid PDL.
35.	Amendment 6 Question #37	P. 15 in the Amendment	Please provide further clarification to Amendment six, response to question 37, which specifies a $2.50 dispensing fee to "Non-independent" pharmacies. Is this a mandatory minimum dispensing fee or can we apply lower dispensing fee reimbursement to pharmacies that may already be	The $2.50 dispensing fee was assumed for non-independent pharmacies for capitation rate development. While there is not a mandatory minimum dispensing fee reimbursement to non-independent pharmacies, the MCO and its PBM must receive active agreement from the pharmacy for participation in the Medicaid network, even if they have an existing contract for non-Medicaid services. Please see Section IV.I.8.b in the RFP.

			contracted with the PBM?	
36.	Amendment 6 Question #210	P. 68 in the Amendment	Answer to Question 210 states: "RFP 5151 Z1 only applies to the MLTC Division." Please confirm that in the event the Legislature were to move responsibility for children in the juvenile justice system back to the Department that MCOs will be responsible only for the same Medicaid costs for these members as when they were under the jurisdiction of the Probation Office.	The MCO will be responsible for the services in the benefits package for Medicaid eligible clients enrolled in the health plan. This responsibility would not be impacted by potential administrative changes regarding the juvenile justice system.
37.	Attachment 19		Please provide the State's definition of an "affiliate", as that term is used in the RFP.	For the purpose of this RFP requirement, an affiliate is considered any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the MCO.
38.	Response to Q &A #301, Attachment 6, Reporting Requirements, and Section IV.T, Reporting and Deliverables.	178	When we originally read and interpreted the RFP Section IV.T and Attachment 6 around the audit requirements, we interpreted the combination of the sections that follow to mean that the annual financial audit conducted of the contracted insurer for purposes of the Nebraska Department of Insurance requirement, which does include obtaining management letters and any	See Attachment 38.

			applicable audit recommendations, would be acceptable for the audit requirement and timeline from the following example: For the contract year ended 12/31/2017, the submission of audited financial statement could be submitted on June 1, 2018, consistent with the audit timing filing with the Nebraska Department of Insurance. However, after reading the response to #301 we are questioning our prior conclusion and requesting further clarification. Upon reading the response to #301, which confirms the Nebraska Department of Insurance filing date (from p.10 of Attach 6) has been amended to read June 1, the response also states that "the deadline for the Audited Financial Statement is 30 calendar days following the 12th month of the contract year". We respectfully request clarification if this response is intentional, and if the Audited Financial Statement (from p.9 of Attach 6) is intended to be the same or different audit requirement? If 30 days after the 12th month of the contract year is intended to mean January 30, 2018 submission of an audited financial statement for	

			the contract year ended 12/31/2017, we respectfully request that be reconsidered as that is a very unusual and aggressive timeline that is unlikely feasible under normal business circumstances. Typically, the full 45 day reporting period is utilized (for example, the time period associated with the quarterly financial reporting required per p.7 of Attachment 6), and there is typically a longer period for preparation of annual financial statements, such as an additional 15 days for a total of 60 days. Then, when there is an audit requirement, there is additional time that is required to allow for the external auditing firm to conduct its fieldwork, testwork, quality control, and audit report issuance processes. For the statutory financial statement audit, this period is three months from the date the statement subject to audit has been prepared (e.g., 2017 contract year financials prepared by the entity by March 1 and then audited by the external audit firm during March-April, and finished in May to allow for the issuance of the audit report by June 1). We respectfully request clarification whether there is a	

			single audit requirement and if the deadline is submission of the audited statutory financial statement, management letter, and any audit recommendations by June 1. Our recommendation is for a single audit financial statement audit requirement that already exists for purposes of the Nebraska Department of Insurance.	
39.	Q	150	Under a value-based provider contract, will the State make allowances for provision of services for which no current encounterable procedure code exists? For example, if the provider/MCO identifies and addresses a member need that likely leads to better health outcomes, but that service is not a covered benefit, is there a mechanism such that the MCO is not "penalized" in the minimum MLR requirement?	A qualifying expense for purposes of the MLR calculation must fall under the categories listed in Attachment 15 – Medical Loss Ratio Requirements. Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.
40.	Q	150	In a value-based provider contract, will the value of the contract be included in the MLR requirement, or the encountered services only?	Only encountered services will be included for purposes of the MLR calculation. Value-based contracting is an evolving concept and MLTC will review policy decisions based on future CMS guidance.
41.	5151Z1 Addendum Seven for Questions and Answers - 221-382	N/A	Please clarify if the vision data includes medical/surgical vision expenditures or merely routine exams, hardware, etc.?	Vision data includes medical/surgical vision expenditures in addition to routine eye exams, hardware, etc.
42.	5151Z1 Addendum	Q. 101	The answer to this question	The 0.25% State Performance Penalty is not a component

	Six for Questions and Answers - 1-220		refers to the answer to question 33, which does not address the State Performance Penalty. Please confirm that amounts both earned and unearned of the State Performance Penalty are factored into the Administrative Cap calculation, in a similar fashion to the QPP holdback.	of the 10% Administrative Cap calculation.
43.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q. 158	Please describe how the savings estimates for the Dual population were developed. What was the benchmark state(s) and what was the data source used to determine that level of savings on a Dual population (where the MCOs are not primary in managing members' care) in the first year of a new program.	Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
44.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 217 and Q. 265	In the answer to these questions, it is stated that all costs within the window are included in the delivery kick payment. However, there are no values included for behavioral health services or pharmacy. Please explain why this would be the case.	These costs are currently not included in the supplemental maternity payment, but are included in the standard rating cohort in which the member resides absent of a delivery event. Behavioral health and pharmacy costs will be included in the supplemental maternity payment in Heritage Health contracts.
45.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	The answer to this question states "The UNMC amount built into the capitation rates will remain the same throughout the <u>entire contract period</u>." Please clarify that this is a typo, and that this portion of the capitation rates will be recalculated each year	The answer to Addendum 7, Question # 221 is amended as follows: The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between

			as part of the rate development and certification process.	6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 "the MCO must calculate the MLR and submit it to MLTC quarterly". The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. **UNMC amounts are revisited each rate cycle, which is typically every 12 months.** The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalities are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:"MLR and Risk Corridor Examples" contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.
46.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 221	Please clarify whether or not the revenue and medical expenses for each of the calculations in this question includes UNMC supplemental payments, and if not, why not, especially since MCOs are at risk for these amounts.	All calculations listed in the response to Addendum 7, Question #221 will be applicable to the UNMC portion of the rate development.
47.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 231 and 232	Please confirm that, as stated in the Second Pre-Proposal Conference, once the MCOs are selected, the quality metrics are finalized, Optumas will perform an analysis to ensure that paid rates, including the portion of all withholds that is expected to	This is confirmed.

			be reasonably achievable by MCOs, fall within the actuarially sound rate range.	
48.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 240	Regarding Critical Access Hospitals: a. Please split out cost settlement (i.e., amounts paid above Medicaid) in the base data. b. Please share the list of adjustments (e.g., trend) and the values that were applied to these settlement amounts when developing the rates in Attachment 11.	The base data contains $8.3 million dollars in Critical Access Hospital settlement payments made outside of the claim/encounter payment system for FY14 and $8.1 million for FY15. The Critical Access Hospital settlements are added into the base data. As such, all rate adjustments outlined in Attachment 22 are applicable to the Critical Access Hospital portion of the capitation rate.
49.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 243	Regarding FQHCs and RHCs: a. Please provide the 1/1/16 APM payment schedules. b. Please clarify that under the new APM methodology effective 1/1/16, the FQHCs and RHCs will no longer cost settle with the state since the APM will reflect full payment to these facilities.	The 1/1/16 APM payment schedules are not currently available for public release. The State does not cost settle with FQHCs and/or RHCs.
50.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 244	Please confirm whether or not historical encounter/FFS data for physical and behavioral health services (i.e., non-pharmacy) under the contract, will be provided to plans upon member assignment.	Please see response to Addendum 7, Question #244.
51.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 245	Please clarify whether or not claims broker services will be needed for all services paid though fee for service (even for those members in managed care) in addition to	The Claims Broker will potentially handle all FFS claims. This could include Long-term Services and Supports related claims as those services are not currently included in the Heritage Health program. However, this will be dependent on final timing of CBS implementation and other program decisions regarding LTSS.

			all populations receiving benefits through fee for service. (For example, will long term services and supports be included for those managed care members receiving those services through fee for service?)	
52.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	In the answer to this question, it is stated that "The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back" but our calculations (based on the data and assumptions provided by Optumas) do not show that the QPP hold-back of 1.5% has explicitly been added into the rates. Please clarify how the QPP hold-back of 1.5% of premium is added to the rates.	Rates are developed based on reported base data, not capitation payments. Since rates are developed using reported experience, there is no need to add in an additional 1.5%. When the rates are finalized, the State's actuaries will remove the withhold consistent with CMS guidance.
53.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 254	Please confirm the value to which the 1.5% is applied to calculate the amount to be deposited into the reinvestment accounts: does this amount include NML? UNMC Supplemental payments? Or is it just 1.5% of the Medical PMPM?	The 1.5% hold back referenced in Section IV.P.10 and required by Neb. Rev. Stat. §71-831 (Attachment 13) is 1.5% of the capitation payment.
54.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 257	The answer to this question refers to a different question that does not address the definitions of related parties. Please confirm that all references to related parties for each of the admin cap, risk corridor, and MLR calculation	The response to Addendum 7, Question #257 is hereby amended to read: "See response to Question #53." References to related parties in the RFP refer to the same definition of related parties contained in the Glossary of Terms.

			refer to the same definition of related parties.	
55.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 259	Please summarize the values of both adjustments made to the rates for copays: a. Reduction embedded in base data to reflect amounts actually collected by providers over the base years. b. Reduction made during rate development process to reflect additional amounts not collected, but representative of all copays (mandatory and voluntary) being collected.	The reduction embedded in the base data reflecting amounts collected by current MCOs is not available. The amount paid by the MCOs is used as the basis for rate development, so the collected copays are not itemized. The adjustment to account for uncollected copays is a 0.02% reduction to the rates for traditional Physical Health managed populations, a 0.03% reduction for the LTSS populations, and no change for the Dual population.
56.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 261	Please provide a detailed list of all of the adjustments made to the encounter data (e.g., CAH settlements, PCP shared risk agreements) that are added in to the base data to reconcile to MCO financial statements.	Please see Attachments 34 and 35 for a complete list of program changes necessary to get from base data shown in Attachment 10 to the final rates shown in Attachment 11.
57.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	Please clarify that deliveries with a qualifying procedure code which resulted in a stillbirth were not considered to be "qualifying delivery events" and please also confirm how the term stillbirth is defined, including weeks gestation.	The response to Addendum 7, Question #265 is hereby amended and superseded with the following: A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. ~~Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate.~~ **The State pays a supplemental payment for live birth events and only those expenses are in the supplemental payment.** When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category.

				The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.
58.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 265	Please provide each of the following **by rate cell and region:** 1) A count of qualifying deliveries during the base period 2) The associated dollars removed from the rate cell due to these deliveries Also, to the extent that the total deliveries and dollars removed do not add up to the	Please see Attachment 37.

			total dollars and deliveries used for the maternity kick payment for each of the two regions, please provide a reconciliation to explain the discrepancy.	
59.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 270	The answer to this question refers to Attachment 22 and Attachment 20. Please provide 1) a crosswalk that shows how the descriptions in Attachment 22 (narrative) align to the adjustments in Attachment 20 or elsewhere. 2) a new attachment that breaks out each of these impacts as requested, including breaking out the impacts into their COS and COA specific components, ideally also breaking the impacts out between any values included within the base data and applied between Attachment 10 and Attachment 11, and also indicating whether the changes are unit cost changes or utilization changes.	Please see Attachments 34 and 35.
60.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 272	Please confirm that the rates have not been reduced for MCO-collected supplemental Rx rebates. These are typically reflected in MCOs' financial statements and if data was adjusted to match these statements, reductions	Rates have not been reduced by rebates. The existing managed care program does not include pharmacy and therefore comments surrounding reported rebates are irrelevant to this rate cycle.

			for rebates could be embedded in the base data.	
61.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q. 313	We know the state indicated that this question would be answered in the second round of questions, but just want to include this question here to ensure that it is not overlooked.	Please see Addendum 10.
62.	Addendum Three: Revisions to the RFP	1	Questions regarding the Auto-Assignment Algorithm 1) How long is the initial Heritage Health enrollment period? 2) After the initial Heritage Health enrollment period ends, will the auto assignment algorithm take into consideration the enrollee's previous MCO assignment? 3) What steps would be taken to ensure that MCOs who contracted with the state prior to the contract period do not get a disproportionate share of members, or a significantly different mix of members than entering plans?	The initial Heritage Health enrollment period will begin October 1, 2016 and end December 16, 2016. Medicaid-covered individuals who have not made a Heritage Health plan choice on December 16 or whose Medicaid eligibility determination is made between December 17 and 31 will be auto-assigned to a Heritage Health plan. The auto-assignment algorithm will not take into consideration previous MCO assignment except in cases where the member is automatically reenrolled in his or her previous MCO because he or she loses Medicaid eligibility for a period of 2 months or less per 42 CFR § 438.56(g) as referenced in IV.B.7.c.ii.b). Per IV.B.3.e, "After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction." Per IV.B.3.f.iii, "If a MCO's membership is comprised of 40% or more of total statewide enrollment at the end of any quarter, that plan will be removed from the auto-assignment round robin process for the following quarter but members can continue to pro-actively select that plan."
63.	Attachment 21	N/A	Please confirm that the values in this exhibit are shown as a percent of the rate exclusive of the UNMC supplemental payment	Non-medical load will apply to the UNMC portion of the rate when rates are finalized in early 2016.
64.	Attachment 21	N/A	Since the UNMC	Please see the response to Question #63 above.

			Supplemental payments represent increased reimbursement that the MCOs are responsible for and at risk for, why are these not included in the rate development (Att. 11) as a medical costs, so that NML is applied to the amounts as well? We believe the NML percentages should be of revenue inclusive of the UNMC supplemental payments.	
65.	Attachment 22	p. 3	A number of program changes, both historical and anticipated, are described in the narrative. This is very helpful, and we are requesting that additional columns be added in the tables to the right of these descriptions to indicate the impact on the rates, and where that impact can be found (populations, services, base data, policy change factors, etc.) with additional exhibits as appropriate to describe particularly complex adjustments.	Please see Attachment 35.
66.	Attachment 23	N/A	Thank you for providing this additional detail for trends by COA and COS. Please also extend the exhibit to show the trends used for each of the four LTC categories, the Katie Beckett members, and Duals.	Katie Beckett is considered AABD for trend setting purposes. LTC categories and Duals used the same assumptions as the AABD population.
67.	Attachment 26	Example 1	In each of the risk corridor and	This information will be posted to the procurement

			MLR calculations, the qualified medical expenses are shown in the same way, including the activities that improve healthcare quality. Based on the glossary (p. xiii) this amount is defined differently for each of the two calculations, such that activities that improve healthcare quality are not included in net qualified medical expense for the risk corridor.	website no later than December 24, 2015.
68.	Attachment 26	Example 1 and Example 2	Please revise the examples to show how each of the following components of revenue would be handled within these examples: 1) UNMC payments 2) Hold-back (earned and unearned) 3) State Performance Penalty (earned and unearned)	This information will be posted to the procurement website no later than December 24, 2015.
69.	Attachment 26	Example 1 Risk Corridor	Please provide additional detail regarding the $8,000 shown as "Total Allowed Administration." In particular, we would expect that no more than $7,000 of this number (7% of revenue) would be for activities not categorized directly to improve healthcare quality, which would leave $1,000 for activities that do improve healthcare quality. Additionally, we would expect this value to be shown in the line labeled "activities that	This information will be posted to the procurement website no later than December 24, 2015.

			improve healthcare quality"	
70.	Attachment 26	Example 1 Risk Corridor	Please provide another example where the amount spent on admin expenses is higher than the total allowed	This information will be posted to the procurement website no later than December 24, 2015.
71.	Attachments 10-11	N/A	Please provide a detailed crosswalk that defines the logic used to determine the categories of service used in this development, using CPT codes, place of service information, or any other information needed to determine the categories of service. Please also ensure that this detailed crosswalk includes logic for services that are excluded under the contract, in particular, long term services and supports.	As the detailed category of service logic is specific to the data elements reported in the encounter data for each of the current managed care entities, the State cannot provide this information as it is proprietary information.
72.	Attachments 10-11	N/A	Please confirm/edit/add to the following list of rate items expected to be reviewed in Spring 2016. a. HEP-C b. Retroactive Enrollment c. UNMC supplemental payments d. CAHs cost settlement amounts e. Provider rate changes (e.g., FQHC) f. Health Insurer Fee/Tax g. Program changes such as ASD, DD h. Foster care behavioral health experience i. Updated trends	All items on this list will be considered in the rate certification in the Spring of 2016. In addition to the items on this list, the Maternity case rate will be revisited to capture pharmacy and behavioral health costs. Additionally, the State's actuaries anticipate using additional runout from FFS data and current Managed Care entities. No changes to the base period are anticipated.

73.	Attachments 10-11	N/A	What are the drivers in the pmpm increases seen in the behavioral health component of the ABD populations? Is it new benefits, acuity, member mix? In particular, we saw PMPMs for these services in the range of $70 between 2009 and 2011, and these services are now upwards of $100.	The historical ABD population for behavioral health managed care is spread across the AABD populations in Attachments 10-A and 10-B, the Dual population in Attachment 10-C, and the LTSS population in Attachment 10-D. The average behavioral health PMPM weighted on the membership of each of these populations is consistent with the $70 quoted in the question.
74.	Attachments 10-11	N/A	Please provide additional breakouts in the category of service lines in all of Attachment 10's to split out utilization and unit cost for each of the following: 1) Pharmacy Expenditures - Hepatitis C 2) Pharmacy Expenditures - Non-Hepatitis C 3) For each inpatient and outpatient category, please split into hospital type: Critical Access Hospital, out-of-state hospital, other	This information will be posted to the procurement site no later than December 24, 2015.
75.	Attachment 11	Lower Bound of Rates	Please confirm the following conveyed at the pre-proposal conference. The rates in Attachment 11 include all of the following items at the stated values: a) Non-QI admin at 7%, b) QPP at 1.5%, c) QI admin at 3%, d) Perf Guar at 0.25%, and e) profit, risk and contingencies at 2%	Slide 15 of the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" itemizes the components of the non-medical load. Please see Attachment 21 for the breakout of the non-medical load components by cohort. The 1.5% QPP is a withhold from the rates, so it is not added in as a component of non-medical load. Rather, it is withheld from the non-medical load rates.

76.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please describe what adjustments have been built into the rates to account for Hep C treatment. Given the number and costly drugs recently available in addition to recent news from CMS about utilizing these benefits, we would like a better understanding of what is included in the rates.	Hepatitis C drug utilization in Nebraska has historically been low. However, the higher pharmacy trend is meant to reflect potential increase in both average unit cost and utilization related to breakthrough therapies.
77.	5151Z1 Addendum Seven for Questions and Answers - 221-382	Q262	Please provide the state's current policy re: when Hep C drugs are allowed to be used for member treatment. Also, please provide a description of how the policy will change in Nebraska.	Current clinical criteria may be found at https://nebraska.fhsc.com/Downloads/NEcriteria_Sovaldi-201409.pdf. A current prior authorization request form may be found at https://nebraska.fhsc.com/Downloads/NEfaxform_HepatitisC-201507.pdf. Clinical criteria and prior authorization forms are reviewed and updated annually and as determined by the State.
78.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	Please provide a count these special populations - by region, rate cell, etc.	This level of detail is not available.
79.	5151Z1 Addendum Six for Questions and Answers - 1-220	Q200	How are MCOs expected to identify these people? Is pharmacy data expected to be adequate for the identification of these members?	Pharmacy data will be provided to bolster any additional mechanisms a MCO has to assess a member for SHCN. Furthermore, per IV.E.22.d and IV.E.22.e, PCPs must notify the MCO of members who meet SHCN criteria and members may also self-identify to either the enrollment broker or the MCO that they have SHCNs.
80.	Attachment 6	Attachment 6, p. 9	Attachment 6 of the contract states HEDIS results are due "45 calendar days following the 12th month of the contract year". NCQA requires HEDIS rates be submitted by June 15th following the measurement year. For	Please see Attachment 38.

			example HEDIS rates for measurement year 2017 would be submitted in June of 2018. Will the state consider changing the due date for HEDIS reporting to align with NCQA timeframes?	
81.	IV.L.4.e.viii Care Management	115	What is the state's definition of "group visits" in this requirement? For example, is this intent for this to be interdisciplinary care team meetings with representatives of the member's unique care team? Are these support groups, i.e. classes/resources in the community? Are these groups facilitated by a provider (e.g. a PCP) on condition self-management?	Group visits include members of the interdisciplinary care team and members of the specialty treatment team as well as members and their families and additional local social and community services supports as necessary.
82.	IV. Project Description and Scope of Work, E. Covered Services, 11. Pharmacy Section, C. Nebraska Medicaid Preferred Drug List	59	After review of the state's PDL, it is noted that the drugs listed on Attachment 8 do not appear to be included in the current PDL posted on the state's website. Does the state have a separate behavioral health preferred drug list that the MCO will be required to implement?	Drugs listed on Attachment 8 are not included in the current PDL posted on the State's website. Attachment 8, which contains required edits for the pharmacy claims system to promote safe prescribing practices for mental health drugs used in children, is unrelated to the PDL. The State does not have a separate preferred drug list for antidepressants, antipsychotics and anticonvulsants.
83.	Z. FFS Claims Management and Processing	191-195	The RFP makes reference to many of the responsibilities of the MCO is awarded the FFS Claims Management and Processing duties. We would like to confirm whether the State will continue to be responsible for managing enrollment processing and	The MCO awarded the FSS Claims Broker contract will only be responsible for the claims-related activities outlined in Section IV.Z. The State, or its designated agent, will continue to oversee program responsibilities including enrollment and member communication for Medicaid-eligible individuals excluded from Heritage Health.

			development of the 834 file to all the MCOs, development of ID cards (including replacement cards) for Fee for Service members, and mailing and development of all member materials and newsletters for Fee for Service members.	
84.	Z. FFS Claims Management and Processing	191-195	In order to meet the requirements for claims processing against duplicates, etc. will the MCO that is chosen to be the FFS Claims broker receive claims history, eligibility history, and prior authorization history for both medical and pharmacy claims. If so, how far back will the claims data go?	MLTC will work with the MCO awarded the Claims Broker contract to provide the MCO with sufficient data to allow the MCO to meet the requirements outlined in Section IV.Z. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
85.	Z. FFS Claims Management and Processing	191-195	Will the state close out any open grievances & appeals or provider claims disputes, open TPL recoveries, complete all claims prior to the date of service that the claims broker implementation date that are active (or have a date of service) prior to the effective date of the FFS claims management contract with the MCO?	All activities outlined in the question will be handled by MLTC for dates of services or claims paid on dates prior to the effective date of the FFS claims management contract. Per IV.Z.3, the implementation of the Claims Broker role is targeted for the second year of the contract to allow sufficient time for MLTC to coordinate on all aspects of the transition with the awarded MCO.
86.	Z. FFS Claims Management, Section 12 Provider Services	194	Will the State continue to enroll Providers and assign the State Medicaid number to all Nebraska providers? Will the state continue to process all Nebraska Medicaid	The State or its designated agent will continue to enroll providers and assign State Medicaid provider numbers to approved providers.

			Provider additions, demographic changes, etc., or will this be the responsibility of the MCO who is awarded the FFS claims management contract?	
87.	Z. FFS Claims Management	191-195	Will the MCO who is selected to serve as the claims broker be responsible for processing dental and non emergent transportation claims?	The MCO awarded the FSS Claims Broker contract will be responsible for processing dental and non-emergency transportation claims if those benefits remain in the FFS program. However, dental services are currently scheduled to be included in a capitated dental benefit manager procurement that is expected to go-live in mid-2017. MLTC continues to evaluate administration of non-emergent transportation benefits.
88.	Attachment 23	557	Please provide a breakout of the assumed trend by utilization and unit cost.	As outlined in the "NE - Heritage Health Second Bidder's Conference Presentation - Optumas", utilization trend and unit cost trend will be provided in early 2016.
89.	Attachment 21	Page 3	For the dual population, what level of managed care is currently being assumed for the members that are currently enrolled in Medicare? What is the basis for this assumption?	The level of Medicare Advantage penetration in the Heritage Health Dual population is not known. Savings estimates for the Dual population are based on the prevalence of Behavioral Health services and anticipated changes in Physical Health experience when the two services are delivered under an integrated program. Duals frequently have a high need for Behavioral Health services, and the databooks provided in Attachment 10-C confirm this for the Heritage Health Dual population. When the care for these Dual enrollees is integrated under one delivery system, it is anticipated that better outcomes for Physical Health needs will occur, leading to a reduction in Physical Health utilization.
90.	Attachment 20	Attachment 20	For pharmacy, how were high cost hepatitis C drugs considered in the base data? Additionally, what considerations were made with regard to these drugs in setting the pharmacy trend? How does FY 14 prescription drug costs compare to FY 15	Please see the response to Question #76 above. Pharmacy costs by year will be provided to awarded MCOs in early 2016.

			costs by region and rate cell?	
91.	Attachment 21	4	Can you provide a summary of the most up to date analysis on the impact of the AP to APR DRG change? When was this analysis completed? Has the recent increase in high dollar inpatient NICUs been factored into this analysis?	Please refer to Attachment 22 for a thorough description of the analysis of the change from AP to APR DRG. This analysis was conducted in the Fall of 2015. NICUs expenditures are included in the base data and were reviewed for the DRG conversion analysis. The AP to APR DRG conversion increased expenses for the maternity case rate.
92.	Addendum Eight - Revised Schedule of Events	Page 1 (Addendum 8)	Will the agency release a revised "Request for Proposal For Contractual Services Form" to reflect the new "Opening Date and Time"?	No, the State will not release a revised “Request for Proposal For Contractual Services Form”.
93.	Attachment 2	1	What are the network access standards for vision, hearing, durable medical equipment , laboratory serves, home health, skilled nursing facilities, hospice, ambulatory surgical center, respite, physical therpay, occuapationa therory, speech therapy, if any?	Please see Attachment 2 for all current network standards.
94.	Addendum 3, RFP § IV(E)(29)(h)	1	Addendum 3 adds the following sentence as new section IV.E.29.h: Non-emergency transportation (except as indicated in Section IV.E.8.a) - Does this mean that non-emergency transportation is excluded (carved out for the State to manage) and MCOs are not required to provide member transportation?	Non-emergency transportation is excluded (“carved out”), with the exception of non-emergency ambulance transportation, which is included (“carved in”).
95.	Attachment 6 -	7	We would like to request	Critical incidents for the purpose of Critical Incident

	Quarterly Deliverables		further clarification regarding the Critical Incident Reporting requirement referenced in Attachment 6, in particular: • How does Nebraska define "critical incident"? • In some states, critical incident reporting relates only to members in long-term care. Is this also the case in Nebraska? • Please confirm that MCOs are only required to collect critical incident reports from behavioral health facilities.	Reporting per Attachment 6 include the following when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit: • Suicide attempt • Suicide death • Non-suicide death • Unexpected death • Homicide • Homicide attempt • Allegation of abuse/neglect (physical) • Allegation of abuse (psychological) • Fire setting or property damage • Medication error resulting in requiring medical intervention • Adverse drug reaction • Unauthorized leave • Accidental injury with significant medical intervention • Emergency medical treatment resulting from injury, medication error, or adverse medication reaction • Use of restraints or seclusion requiring significant medical intervention • Unusual, unexpected illness or disease • Other serious occurrence, including sexual contact between peers or peers and staff which member is under treatment The RFP requires critical incident reporting related to behavioral health providers only.
96.	RFP § IV (B)(2)(d) and RFP § IV (B)(5)(c)	33 & 36	Please confirm how much time the MCO is required to allow members to choose a PCP. RFP § IV(B)(2)(d) indicates 15 days and RFP § IV(B)(5)(c) indicates 10 days.	Members have 15 days to elect a MCO and may elect PCP within this timeframe. After MCO assignment, members have an additional ten days to elect a PCP. The MCO may elect to auto-assign the member as early as the 11th day, but must auto assign the member to a PCP within one month of the enrollment date.
97.	RFP § IV (I)(14)(b)	100	This provision requires that all providers be credentialed	There is no required credentialing timeframe prior to the contract start date.

			within 30 calendar days upon receipt of a completed credentialing application. Please confirm that the 30-day credentialing timeframe applies only after the Contract goes live.	
98.	RFP § IV(M)(1)(b)	118	We understand MLTC's quality strategy has been submitted to CMS for approval. Can MLTC a draft of the submitted quality strategy for preliminary review?	The MLTC Quality Strategy is currently under revision to come into compliance with proposed managed care regulation changes.
99.	RFP § IV(O)(17)	141	Following up on Round 1 Q&A #156, please confirm that the MCO will not be required to consult with NMPI and MFPAU in connection with recouping overpayments due to TPL, retroactive reductions to state fee schedules, members that were retrospectively disenrolled by the state and similar situations.	Please see the response to Addendum 6, Question #156.
100.	RFP § IV(Q)(6)(b)	150	The State indicated in response to Question 103 of the first round of questions that the 30% and 50% of the provider network measure includes all providers in the network. Would this include ancillary services such as laboratories, pharmacies, DME, radiologists, therapy services, etc.?	Please see the response to Addendum 6, Question #102. All providers in the network including ancillary services will be considered in the denominator.
101.	RFP § V(A)(2)(h)	197	We wanted to follow up on Question 174 from the first	The budget refers to the contract value. Please provide original contract value projections and actual contract value.

			round of Q&A. The State indicated that the originally scheduled budget and actual budget mean the project budget and the actual budget. What type of information would this be in the case of a capitated contract? Payment is made on a pmpm basis; by its structure the rate is simply the rate. Would the amount received by the MCO annually be the responsive information?	
102.	RFP § IV(Q)(11)	152	Will the UNMC payments be a fixed dollar amount each month, or will they vary based on the actual plan utilization with UNMC?	The UNMC payment is a fixed dollar amount.
103.	RFP § IV(Q)(11)	152	Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC portion of the capitation rate be removed when developing the capitation rate risk adjustments in year 2? If the UNMC payment is a fixed dollar amount, it is not actuarially sound to risk adjust these.	Risk adjustment factors will be applied to the aggregate rate, inclusive of UNMC.
104.	RFP § IV(P)(10) and IV(P)(11)	146-147	Given that the state has now advised that the UNMC payments will not be a pass-through and will instead be part of the at-risk capitation payment, will the UNMC	Non-medical load, the QPP Withhold, and the State Performance Penalty will apply to the UNMC portion of the rate.

			portion of the capitation rate be removed when calculating the QPP Withhold and the State Performance Penalty amounts? If the UNMC payment is a fixed dollar amount that must be paid out, it is not actuarially sound to reduce the amounts by the withhold and penalty amounts.	
105.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business? EG: what would the award criteria be?	Please see the response to Addendum 7, Question # 278.
106.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	The posted HIPAA 5010 837I and 837P Companion Guides apply for both FFS and Encounter submissions, and contain only requirements that clarify state-specific usage of the standard transaction documented in the respective ASC X12 TR3 Implementation Guides. Exceptions where requirements differ in the companion guides for FFS and Encounter are identified as “Chargeable” for FFS submissions and “Reporting” for Encounter submissions. The State returns HIPAA 837 file acknowledgements via HIPAA 5010 999/TA1 Transactions. Encounter submission results are also sent via HIPAA 5010 277Claim Acknowledgement Transaction. In addition, a month-to-date error summary and acceptance percentage report is sent in a proprietary format.

107.	Attachments 30 & 31, and Question & Answer #304 (11.19.15) RFP Section IV.B.12	Attachment 30 Attachment 31 Q/A Part 2, page 34 IV.B.12, page	The NE Medicaid 5010 Companion Guide for 834 transactions (published 3/12/13) is very short and only specifies sender and receiver IDs. Our question: although the monthly enrollment file as specified in Attachment 30 is not an 834 format, does MLTC's 834 eligibility file contain the same *data elements* as the monthly enrollment file as specified in Attachment 30?	The posted HIPAA 5010 834 Companion Guide contains only requirements that clarify state-specific usage of the standard transaction documented in the ASC X12 TR3 Implementation Guide. The Nebraska Medicaid Managed Care Client Eligibility Data Supplemental Enrollment File in Attachment 30 is a proprietary supplement to the HIPAA 5010 834 Benefit Enrollment and Maintenance Transaction which contains additional data that cannot be reported in the 834 transaction. There is limited data element duplication in the 834 and the supplemental files to enable the MCO to tie the data in the two files for each client.
108.	RFP Section IV.S.10.x RFP Section IV.P.13	IV.S.10.x: p.171 IV.P.13: p.148	Regarding this sentence: *Control totals will also be reviewed and verified. Additionally, the MCO must reconcile all encounter data submitted to the State to control totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 6 – Reporting Requirements*. We cannot find information in Attachment 6 that relates to MLR reports or reconciliation of encounter data to MLR reports. Does MLTC have additional information that is intended for inclusion in Attachment 6?	Quarterly and annual financial reporting requirements included in Attachment 6 reference Section IV.T – Reporting and Deliverables. IV.T.5 contains a list of required reports including IV.T.5.v – Medical loss ratio calculation.
109.	RFP Section IV.R.13.a	161	Regarding this sentence: *The MCO must have online retrieval and access to documents and files for six (6)*	MLTC will develop a policy in coordination with awarded MCOs in regards to the final disposition of claims with a once-in-a-lifetime indicator.

			years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Does the second sentence override the first sentence? Specifically: how long must the MCO maintain "once-in-a-life-time" claims online - greater than 10 years? Wouldn't MLTC be better served to require MCO's to turn over such claims data to MLTC after 10 years?	

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM EIGHT
REVISED SCHEDULE OF EVENTS

Date: November 20, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

NEW Opening Date: January 5, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
8	Last day to submit Second Round written questions	~~November 23, 2015~~ **November 30, 2015**
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~December 7, 2015~~ **December 18, 2015**
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	~~December 22, 2015~~ **January 5, 2016** 2:00 PM Central Time
11	Review for conformance of mandatory requirements	~~December 22, 2015~~ **January 5, 2016**
12	Evaluation period	~~January 6, 2016 –~~ ~~January 22, 2016~~ **January 12, 2016 –** **January 29, 2016**
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~January 29, 2016~~ **February 5, 2016**

	ACTIVITY	DATE/TIME
15	Contract finalization period	~~January 29, 2016 –~~ ~~February 29, 2016~~ **February 5, 2016 – March 15, 2016**
16	Contract award	~~March 1, 2016~~ **March 15, 2016**
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA MEDICAID MANAGED CARE

UNBORN FILE

OCTOBER 25, 2013

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DOCUMENT SUMMARY **1**

NEBRASKA MANAGED CARE UNBORN FILE DATA RECORD LAYOUT **2**

H RECORD - UNBORN HEADER RECORD 2
N, C, E RECORD - UNBORN DETAIL RECORD 3
T RECORD - UNBORN TRAILER RECORD 4

NOTES FOR HEALTH PLAN UNBORN HEADER DATA RECORD - "H" RECORD **6**

FIELD HHH NEBRASKA MANAGED CARE UNBORN HEADER RECORD 6
FIELD H01 HEADER ACTION TYPE 6
FIELD H02 HEADER DATE/TIME STAMP 6

NOTES FOR HEALTH PLAN UNBORN DETAIL DATA RECORD - "D" RECORD **7**

FIELD DDD NEBRASKA MANAGED CARE UNBORN DETAIL RECORD 7
FIELD D01 DETAIL ACTION TYPE 7
FIELD D02 UNBORN MEDICAID IDENTIFICATION NUMBER 7
FIELD D03 EXPECTED DATE OF BIRTH 7
FIELD D04 MOTHERS NAME 7
FIELD D05 HEAD OF THE HOUSEHOLD NAME 8
FIELD D06 HEAD OF HOUSEHOLD ADDRESS - LINE 1 8
FIELD D07 HEAD OF HOUSEHOLD ADDRESS - LINE 2 8
FIELD D08 HEAD OF HOUSEHOLD ADDRESS - LINE 3 8
FIELD D09 HEAD OF HOUSEHOLD CITY 8
FIELD D10 HEAD OF HOUSEHOLD STATE 8
FIELD D11 HEAD OF HOUSEHOLD ZIP CODE 8
FIELD D12 HEAD OF HOUSEHOLD ZIP 4 9
FIELD D13 XREF MEDICAID IDENTIFICATION NUMBER 9
FIELD D14 FETAL NUMBER 9

NOTES FOR HEALTH PLAN UNBORN TRAILER DATA RECORD - "T" RECORD **10**

FIELD TTT NEBRASKA MANAGED CARE UNBORN TRAILER RECORD 10
FIELD T01 TRAILER ACTION TYPE 10
FIELD T02 TRAILER DATE/TIME STAMP 10
FIELD T03 TOTAL DETAIL RECORD 10

DOCUMENT SUMMARY

This document describes the Nebraska Medicaid Managed Care Program record layout used by the State of Nebraska to send information regarding unborn clients to the health plans.

This file will be sent daily and monthly. It will include unborn clients that have either the mom or a sibling enrolled with the health plan.

The file characteristics are:

a. Record length = 500

b. The first record in the file must be a header record

c. The last record in the file must be a trailer record.

d. All date fields must be in **YYYY**MMDD format.

NEBRASKA MANAGED CARE UNBORN FILE DATA RECORD LAYOUT

H RECORD - Unborn Header Record

```
                                                                    Required/
COBOL Record Layout                                                 Optional    Field   Position

01  NMC-UNBORN-HDR.                                                                HHH     001-500
    03  NMC-HDR-ACTION-TYPE            PIC X     VALUE 'H'.          R         H01     001-001
    03  NMC-HDR-DATE-STAMP.                                          R         H02     002-015
        05  NMC-HDR-SYSTEM-DATE.
            10  NMC-HDR-SYSTEM-YEAR    PIC 9(04) VALUE 0.
            10  NMC-HDR-SYSTEM-MONTH   PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-DAY     PIC 9(02) VALUE 0.
        05  NMC-HDR-SYSTEM-TIME.
            10  NMC-HDR-SYSTEM-HOUR    PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-MINUTE  PIC 9(02) VALUE 0.
            10  NMC-HDR-SYSTEM-SECOND  PIC 9(02) VALUE 0.
    03  FILLER                         PIC X(485).                                 016-500
```

N, C, E RECORD - Unborn Detail Record

COBOL Record Layout		Required/ Optional	Field	*Position*
01 NMC-UNBORN-DET.			DDD	001-500
03 NMC-ACTION-TYPE	PIC X.	R	D01	001-001
03 NMC-UNBORN-DETAIL.				
05 NMC-UNBORN-MEDICAID-NBR.		R	D02	002-012
10 NMC-UNBORN-CASE-NBR	PIC 9(09) VALUE 0.			
10 NMC-UNBORN-CASE-ID	PIC 9(02) VALUE 0.			
05 NMC-EXPECTED-DATE-OF-BIRTH.		R	D03	013-020
10 NMC-EXPECTED-DOB-YEAR	PIC X(04).			
10 NMC-EXPECTED-DOB-MONTH	PIC X(02).			
10 NMC-EXPECTED-DOB-DAY	PIC X(02).			
05 NMC-MOM-NAME.		R	D04	021-066
10 NMC-MOM-FNAME	PIC X(20).			
10 NMC-MOM-MINIT	PIC X.			
10 NMC-MOM-LNAME	PIC X(25).			
05 NMC-HEAD-OF-HOUSE-NAME.		R	D05	067-096
10 NMC-HOH-FNAME	PIC X(10).			
10 NMC-HOH-MINIT	PIC X.			
10 NMC-HOH-LNAME	PIC X(19).			
05 NMC-HOH-MAILING-ADDRESS.				
10 NMC-MAILING-ADDRESS1	PIC X(50).	R	D06	097-146
10 NMC-MAILING-ADDRESS2	PIC X(50).	O	D07	147-196
10 NMC-MAILING-ADDRESS3	PIC X(50).	O	D08	197-246
10 NMC-MAILING-CITY	PIC X(25).	R	D09	247-271
10 NMC-MAILING-STATE	PIC X(02).	R	D10	272-273
10 NMC-MAILING-ZIP-CODE	PIC 9(05) VALUE 0.	R	D11	274-278
10 NMC-MAILING-ZIP-4	PIC 9(04) VALUE 0.	O	D12	279-282
05 NMC-XREF-MEDICAID-NBR.		R	D13	283-293
10 NMC-XREF-CASE-NBR	PIC 9(09) VALUE 0.			
10 NMC-XREF-CASE-ID	PIC 9(02) VALUE 0.			
05 NMC-FETAL-NBR	PIC 9(4) VALUE 0.	R	D14	294-297
05 FILLER	PIC X(203).			298-500

T RECORD - Unborn Trailer Record

COBOL Record Layout			Required/ Optional	Field	*Position*
01 NMC-UNBORN-TRL.				TTT	001-500
03 NMC-TRL-ACTION-TYPE	PIC X VALUE 'T'.		R	T01	001-001
03 NMC-TRL-DATE-STAMP.			R	T02	002-015
05 NMC-TRL-SYSTEM-DATE.					
10 NMC-TRL-SYSTEM-YEAR	PIC 9(04)	VALUE 0.			
10 NMC-TRL-SYSTEM-MONTH	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-DAY	PIC 9(02)	VALUE 0.			
05 NMC-TRL-SYSTEM-TIME.					
10 NMC-TRL-SYSTEM-HOUR	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-MINUTE	PIC 9(02)	VALUE 0.			
10 NMC-TRL-SYSTEM-SECOND	PIC 9(02)	VALUE 0.			
03 NMC-TOTAL-DETAIL-RECORDS	PIC 9(07)	VALUE 0.	R	T03	016-022
03 FILLER	PIC X(478).				023-500

NEBRASKA MEDICAID MANAGED CARE

UNBORN FILE DATA

Document B: Health Plan Unborn File Data Descriptive Notes

NOTES FOR HEALTH PLAN UNBORN HEADER DATA RECORD - "H" RECORD

Field HHH Nebraska Managed Care Unborn Header Record

Field Name: NMC-UNBORN-HDR
Purpose: This is the Unborn Header Data Record.
Valid Values: Follow.

Field H01 Header Action Type

Field Name: NMC-HDR-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'H'.

Field H02 Header Date/Time Stamp

Field Name: NMC-HDR-DATE-STAMP

NMC-HDR-SYSTEM-DATE	
NMC-HDR-SYSTEM-YEAR	PIC 9(04)
NMC-HDR-SYSTEM-MONTH	PIC 9(02)
NMC-HDR-SYSTEM-DAY	PIC 9(02)
NMC-HDR-SYSTEM-TIME	
NMC-HDR-SYSTEM-HOUR	PIC 9(02)
NMC-HDR-SYSTEM-MINUTE	PIC 9(02)
NMC-HDR-SYSTEM-SECOND	PIC 9(02)

Purpose: The header record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format

NOTES FOR HEALTH PLAN UNBORN DETAIL DATA RECORD - "D" RECORD

Field DDD Nebraska Managed Care Unborn Detail Record

Field Name: NMC-UNBORN-DET
Purpose: This is the Unborn Detail Data Record.
Valid Values: Follow.

Field D01 Detail Action Type

Field Name: NMC- ACTION-TYPE PIC X.
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: N = New - First time unborn is being sent to plan
C = Continue - Unborn continues to be assigned to plan
E = End - Pregnancy has ended or unborn is no longer assigned to plan

Field D02 Unborn Medicaid Identification Number

Field Name: NMC-UNBORN-MEDICAID-NBR.
NMC-UNBORN-CASE-NBR PIC 9(09) VALUE 0.
NMC-UNBORN-CASE-ID PIC 9(02) VALUE 0.

Purpose: 11-digit Medicaid number assigned by Health and Human Services to a person who has applied and is eligible for public assistance benefits. This number consists of a Medicaid case number and a client identification number within that case.
REQUIRED: YES
Valid Values: 11-digit Medicaid number.

Field D03 Expected Date of Birth

Field Name: NMC-EXPECTED-DATE-OF-BIRTH.
NMC-EXPECTED-DOB-YEAR PIC X(04).
NMC-EXPECTED-DOB-MONTH PIC X(02).
NMC-EXPECTED-DOB-DAY PIC X(02).

Purpose: This field contains the unborn's expected date of birth.
REQUIRED: YES

Field D04 Mothers Name

Field Name: NMC-MOM-NAME.
NMC-MOM-FNAME PIC X(20).
NMC-MOM-MINIT PIC X.
NMC-MOM-LNAME PIC X(25).
Purpose: This field contains the name of the pregnant mother.
REQUIRED: YES

Field D05 Head of the Household Name

Field Name: NMC-HEAD-OF-HOUSE-NAME
- NMC-HOH-FNAME PIC X(10).
- NMC-HOH-MINIT PIC X.
- NMC-HOH-LNAME PIC X(19).

Purpose: This field contains the case head name associated with the mailing address.
REQUIRED: YES

Field D06 Head of Household Address - Line 1

Field Name: NMC-MAILING-ADDRESS1 PIC X(50)
Purpose: This field contains the first line of the address.
REQUIRED: YES

Field D07 Head of Household Address - Line 2

Field Name: NMC-MAILING-ADDRESS2 PIC X(50)
Purpose: This field contains the second line of the address.
REQUIRED: NO

Field D08 Head of Household Address - Line 3

Field Name: NMC-MAILING-ADDRESS3 PIC X(50)
Purpose: This field contains the third line of the address.
REQUIRED: NO

Field D09 Head of Household City

Field Name: NMC-MAILING-CITY PIC X(25)
Purpose: This field contains the city name.
REQUIRED: YES

Field D10 Head of Household State

Field Name: NMC-MAILING-STATE PIC X(02)
Purpose: This field contains a two-digit state code.
REQUIRED: YES

Field D11 Head of Household Zip Code

Field Name: NMC-MAILING-ZIP-CODE PIC 9(05).
Purpose: This field contains the five-digit postal zip code.
REQUIRED: YES

Field D12 Head of Household Zip 4

Field Name: NMC-MAILING-ZIP-4 PIC 9(04).
Purpose: This field contains the four-digit postal zip code.
REQUIRED: NO

Field D13 XREF Medicaid Identification Number

Field Name: NMC-XREF-MEDICAID-NBR.
NMC-XREF-CASE-NBR PIC 9(09) VALUE 0.
NMC-XREF-CASE-ID PIC 9(02) VALUE 0.

Purpose: Medicaid number of the mom or sibling used to assign the unborn to a plan.
REQUIRED: YES
Valid Values: 11-digit Medicaid number.

Field D14 Fetal Number

Field Name: NMC-FETAL-NBR PIC 9(4)
Purpose: This field contains the number of fetuses of the pregnant mother.
REQUIRED: YES

NOTES FOR HEALTH PLAN UNBORN TRAILER DATA RECORD - "T" RECORD

Field TTT Nebraska Managed Care Unborn Trailer Record

Field Name: NMC-UNBORN-TRL
Purpose: This is the Unborn Trailer Data Record.
Valid Values: Follow.

Field T01 Trailer Action Type

Field Name: NMC-TRL-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'T'.

Field T02 Trailer Date/Time Stamp

Field Name: NMC-TRL-DATE-STAMP

NMC-TRL-SYSTEM-DATE	
NMC-TRL-SYSTEM-YEAR	PIC 9(04)
NMC-TRL-SYSTEM-MONTH	PIC 9(02)
NMC-TRL-SYSTEM-DAY	PIC 9(02)
NMC-TRL-SYSTEM-TIME	
NMC-TRL-SYSTEM-HOUR	PIC 9(02)
NMC-TRL-SYSTEM-MINUTE	PIC 9(02)
NMC-TRL-SYSTEM-SECOND	PIC 9(02)

Purpose: The trailer record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24-hour HHMMSS format.

Field T03 Total Detail Record

Field Name: NMC-TRL-TOTAL-DETAIL-RECORD PIC 9(07)
Purpose: This field contains an accumulated total count of the records in this batch. A batch is the group of records between the header and the trailer record.
REQUIRED: YES

NEBRASKA MEDICAID MANAGED CARE

CLIENT ELIGIBILITY DATA

SUPPLEMENTAL ENROLLMENT FILE REPORT

July 2015

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FIELD D29 SUBSCRIBER SOCIAL SECURITY NUMBER 15
FIELD D30 SUBSCRIBER NAME 15
FIELD D31 RELATION POLICY HOLDER 16
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DOCUMENT SUMMARY

This document describes the Nebraska Medicaid Managed Care Program record layout used by the State of Nebraska to send information regarding Medicaid Managed Care clients enrolled with the health connection vendor(s).

This file will be sent on a monthly basis. It will include all clients who are newly enrolled, clients who were enrolled last month and continue to be enrolled, clients who will transferred into the health plan, and clients who are no longer enrolled with the health plan.

The file characteristics are:

a. EBCDIC format

b. LRECL **=** 1500, RECFM = FB

c. The first record in the file must be a header record

d. The last record in the file must be a trailer record.

e. All date fields must be in YYYYMMDD format.

NEBRASKA MANAGED CARE CLIENT ELIGIBILITY DATA RECORD LAYOUT

H RECORD - Client Eligibility Header Record

(NMCMENRL)

--------- FIELD LEVEL/NAME ----------	-PICTURE-	FIELD -NUMBER	START	END	LENGTH
:E-:NMC-MEDICAID-ENROLL-DATA			1	1500	1500
2 :E-:NMC-MEDICAID-ENROLL-HDR	GROUP	1	1	1500	1500
3 :E-:NMC-HDR-ACTION-TYPE	X	2	1	1	1
3 :E-:NMC-HDR-DATE-STAMP	GROUP	3	2	15	14
5 :E-:NMC-HDR-SYSTEM-DATE	GROUP	4	2	9	8
7 :E-:NMC-HDR-SYSTEM-YEAR	9(4)	5	2	5	4
7 :E-:NMC-HDR-SYSTEM-MONTH	99	6	6	7	2
7 :E-:NMC-HDR-SYSTEM-DAY	99	7	8	9	2
5 :E-:NMC-HDR-SYSTEM-TIME	GROUP	8	10	15	6
7 :E-:NMC-HDR-SYSTEM-HOUR	99	9	10	11	2
7 :E-:NMC-HDR-SYSTEM-MINUTE	99	10	12	13	2
7 :E-:NMC-HDR-SYSTEM-SECOND	99	11	14	15	2
3 FILLER	X(1481)	12	16	1496	1481
3 :E-:NMC-HDR-TRANSMIT-PLAN-NBR	9(4)	13	1497	1500	4

N, C, X, D RECORD - Client Eligibility Detail Record

--------- FIELD LEVEL/NAME ----------	-PICTURE-	FIELD -NUMBER	START	END	LENGTH
2 :E-:NMC-MEDICAID-ENROLL-DET REDEFINES :E-:NMC-MEDICAID-ENROLL-HDR					
2 :E-:NMC-MEDICAID-ENROLL-DET	GROUP	14	1	1500	1500
3 :E-:NMC-ACTION-TYPE	X	15	1	1	1
3 :E-:NMC-ENROLLMENT-DETAIL	GROUP	16	2	1496	1495
5 :E-:NMC-CLIENT-MEDICAID-NBR	GROUP	17	2	12	11
7 :E-:NMC-MEDICAID-CASE-NBR	9(9)	18	2	10	9
7 :E-:NMC-CLIENT-CASE-ID	99	19	11	12	2
5 :E-:NMC-CLIENT-SSN	9(9)	20	13	21	9
5 :E-:NMC-CLIENT-NAME	GROUP	21	22	67	46
7 :E-:NMC-CLIENT-FNAME	X(20)	22	22	41	20
7 :E-:NMC-CLIENT-MIDINIT	X	23	42	42	1
7 :E-:NMC-CLIENT-LNAME	X(25)	24	43	67	25
5 :E-:NMC-MD-PLAN-NUMBER	9(4)	25	68	71	4
5 :E-:NMC-PROVIDER-NUMBER	GROUP	26	72	82	11
7 :E-:NMC-MD-MEDICAID-PROV-NBR	X(9)	27	72	80	9
7 :E-:NMC-MD-MEDICAID-PROV-SFX	99	28	81	82	2
5 :E-:NMC-MD-MEDICAID-PROV-TERM	X	29	83	83	1
5 :E-:NMC-VENDOR-PROV-NBR	X(15)	30	84	98	15
5 :E-:NMC-BH-PLAN-NUMBER	9(4)	31	99	102	4
5 :E-:NMC-CAP-RATES	GROUP	32	103	144	42
7 :E-:NMC-CAP-AMT1	9(5)V99	33	103	109	7
7 :E-:NMC-CAP-AMT2	9(5)V99	34	110	116	7
7 :E-:NMC-CAP-AMT3	9(5)V99	35	117	123	7
7 :E-:NMC-CAP-AMT4	9(5)V99	36	124	130	7
7 :E-:NMC-CAP-AMT5	9(5)V99	37	131	137	7

7 :E-:NMC-CAP-AMT6	9(5)V99	38	138	144	7
5 :E-:NMC-DSS-AGENCY-CODE	GROUP	39	145	149	5
7 :E-:NMC-DSS-DISTRICT	99	40	145	146	2
7 :E-:NMC-DSS-ADM-OFFICE	9	41	147	147	1
7 :E-:NMC-DSS-WORKER	99	42	148	149	2
5 :E-:NMC-CLIENT-LIVING-ARRANGE	99	43	150	151	2
5 :E-:NMC-CLIENT-NATIONALITY	X	44	152	152	1
5 :E-:NMC-IND	GROUP	45	153	156	4
7 :E-:NMC-PREG-RELATED-SERV-IND	X	46	153	153	1
7 :E-:NMC-AUTO-ASSIGN-IND	X	47	154	154	1
7 :E-:NMC-CAP-GENDER	X	48	155	155	1
7 :E-:NMC-SPECIAL-NEEDS-IND	X	49	156	156	1
5 :E-:NMC-REASON-CLOSE-CODE	XXX	50	157	159	3
5 :E-:NMC-LOCK-IN-CODE	X	51	160	160	1
5 :E-:NMC-LOCK-IN-PHARMACY	X(11)	52	161	171	11
5 :E-:NMC-LOCK-IN-PRIM-PRACT	X(11)	53	172	182	11
5 :E-:NMC-LOCK-IN-LICENSE	X(13)	54	183	195	13
5 :E-:NMC-LOCK-IN-OP-HOSP	X(11)	55	196	206	11
5 :E-:NMC-FETAL-NBR	9(4)	56	207	210	4
5 :E-:NMC-MOM-NAME	GROUP	57	211	256	46
7 :E-:NMC-MOM-FNAME	X(20)	58	211	230	20
7 :E-:NMC-MOM-MNAME	X	59	231	231	1
7 :E-:NMC-MOM-LNAME	X(25)	60	232	256	25
5 :E-:NMC-TPL-INFO(1) OCCURS 4 TIMES	GROUP	61	257	410	154
7 :E-:NMC-CARRIER-NBR(1)	GROUP	62	257	264	8
10 :E-:NMC-CARRIER-CODE(1)	X(5)	63	257	261	5
10 :E-:NMC-CARRIER-SEQ-NBR(1)	XXX	64	262	264	3
7 :E-:NMC-CARRIER-NAME(1)	X(30)	65	265	294	30
7 :E-:NMC-POLICY-KEY(1)	GROUP	66	295	334	40
10 :E-:NMC-POLICY-NBR(1)	X(20)	67	295	314	20
10 :E-:NMC-GROUP-NUMBER(1)	X(20)	68	315	334	20
7 :E-:NMC-SUBSCRIBER-SSN(1)	X(9)	69	335	343	9
7 :E-:NMC-SUBSCRIBER-NAME(1)	GROUP	70	344	389	46
10 :E-:NMC-SUBSCR-FIRST(1)	X(20)	71	344	363	20
10 :E-:NMC-SUBSCR-MIDINT(1)	X	72	364	364	1
10 :E-:NMC-SUBSCR-LAST(1)	X(25)	73	365	389	25
7 :E-:NMC-RELATN-POLHLDR(1)	XX	74	390	391	2
7 :E-:NMC-COVERAGE-CODE(1)	XXX	75	392	394	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(1)	GROUP	76	395	410	16
10 :E-:NMC-TPL-START-DATE(1)	GROUP	77	395	402	8
15 :E-:NMC-TPL-YEAR-START(1)	X(4)	78	395	398	4
15 :E-:NMC-TPL-MONTH-START(1)	XX	79	399	400	2
15 :E-:NMC-TPL-DAY-START(1)	XX	80	401	402	2
10 :E-:NMC-TPL-END-DATE(1)	GROUP	81	403	410	8
15 :E-:NMC-TPL-YEAR-END(1)	X(4)	82	403	406	4
15 :E-:NMC-TPL-MONTH-END(1)	XX	83	407	408	2
15 :E-:NMC-TPL-DAY-END(1)	XX	84	409	410	2
5 :E-:NMC-TPL-INFO(2)	GROUP	61	411	564	154

7 :E-:NMC-CARRIER-NBR(2)	GROUP	62	411	418	8
10 :E-:NMC-CARRIER-CODE(2)	X(5)	63	411	415	5
10 :E-:NMC-CARRIER-SEQ-NBR(2)	XXX	64	416	418	3
7 :E-:NMC-CARRIER-NAME(2)	X(30)	65	419	448	30
7 :E-:NMC-POLICY-KEY(2)	GROUP	66	449	488	40
10 :E-:NMC-POLICY-NBR(2)	X(20)	67	449	468	20
10 :E-:NMC-GROUP-NUMBER(2)	X(20)	68	469	488	20
7 :E-:NMC-SUBSCRIBER-SSN(2)	X(9)	69	489	497	9
7 :E-:NMC-SUBSCRIBER-NAME(2)	GROUP	70	498	543	46
10 :E-:NMC-SUBSCR-FIRST(2)	X(20)	71	498	517	20
10 :E-:NMC-SUBSCR-MIDINT(2)	X	72	518	518	1
10 :E-:NMC-SUBSCR-LAST(2)	X(25)	73	519	543	25
7 :E-:NMC-RELATN-POLHLDR(2)	XX	74	544	545	2
7 :E-:NMC-COVERAGE-CODE(2)	XXX	75	546	548	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(2)	GROUP	76	549	564	16
10 :E-:NMC-TPL-START-DATE(2)	GROUP	77	549	556	8
15 :E-:NMC-TPL-YEAR-START(2)	X(4)	78	549	552	4
15 :E-:NMC-TPL-MONTH-START(2)	XX	79	553	554	2
15 :E-:NMC-TPL-DAY-START(2)	XX	80	555	556	2
10 :E-:NMC-TPL-END-DATE(2)	GROUP	81	557	564	8
15 :E-:NMC-TPL-YEAR-END(2)	X(4)	82	557	560	4
15 :E-:NMC-TPL-MONTH-END(2)	XX	83	561	562	2
15 :E-:NMC-TPL-DAY-END(2)	XX	84	563	564	2
5 :E-:NMC-TPL-INFO(3)	GROUP	61	565	718	154
7 :E-:NMC-CARRIER-NBR(3)	GROUP	62	565	572	8
10 :E-:NMC-CARRIER-CODE(3)	X(5)	63	565	569	5
10 :E-:NMC-CARRIER-SEQ-NBR(3)	XXX	64	570	572	3
7 :E-:NMC-CARRIER-NAME(3)	X(30)	65	573	602	30
7 :E-:NMC-POLICY-KEY(3)	GROUP	66	603	642	40
10 :E-:NMC-POLICY-NBR(3)	X(20)	67	603	622	20
10 :E-:NMC-GROUP-NUMBER(3)	X(20)	68	623	642	20
7 :E-:NMC-SUBSCRIBER-SSN(3)	X(9)	69	643	651	9
7 :E-:NMC-SUBSCRIBER-NAME(3)	GROUP	70	652	697	46
10 :E-:NMC-SUBSCR-FIRST(3)	X(20)	71	652	671	20
10 :E-:NMC-SUBSCR-MIDINT(3)	X	72	672	672	1
10 :E-:NMC-SUBSCR-LAST(3)	X(25)	73	673	697	25
7 :E-:NMC-RELATN-POLHLDR(3)	XX	74	698	699	2
7 :E-:NMC-COVERAGE-CODE(3)	XXX	75	700	702	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(3)	GROUP	76	703	718	16
10 :E-:NMC-TPL-START-DATE(3)	GROUP	77	703	710	8
15 :E-:NMC-TPL-YEAR-START(3)	X(4)	78	703	706	4
15 :E-:NMC-TPL-MONTH-START(3)					

	XX	79	707	708	2
15 :E-:NMC-TPL-DAY-START(3)					
	XX	80	709	710	2
10 :E-:NMC-TPL-END-DATE(3)					
	GROUP	81	711	718	8
15 :E-:NMC-TPL-YEAR-END(3)					
	X(4)	82	711	714	4
15 :E-:NMC-TPL-MONTH-END(3)					
	XX	83	715	716	2
15 :E-:NMC-TPL-DAY-END(3)					
	XX	84	717	718	2
5 :E-:NMC-TPL-INFO(4)	GROUP	61	719	872	154
7 :E-:NMC-CARRIER-NBR(4)					
	GROUP	62	719	726	8
10 :E-:NMC-CARRIER-CODE(4)					
	X(5)	63	719	723	5
10 :E-:NMC-CARRIER-SEQ-NBR(4)					
	XXX	64	724	726	3
7 :E-:NMC-CARRIER-NAME(4)					
	X(30)	65	727	756	30
7 :E-:NMC-POLICY-KEY(4)	GROUP	66	757	796	40
10 :E-:NMC-POLICY-NBR(4)					
	X(20)	67	757	776	20
10 :E-:NMC-GROUP-NUMBER(4)					
	X(20)	68	777	796	20
7 :E-:NMC-SUBSCRIBER-SSN(4)					
	X(9)	69	797	805	9
7 :E-:NMC-SUBSCRIBER-NAME(4)					
	GROUP	70	806	851	46
10 :E-:NMC-SUBSCR-FIRST(4)					
	X(20)	71	806	825	20
10 :E-:NMC-SUBSCR-MIDINT(4)					
	X	72	826	826	1
10 :E-:NMC-SUBSCR-LAST(4)					
	X(25)	73	827	851	25
7 :E-:NMC-RELATN-POLHLDR(4)					
	XX	74	852	853	2
7 :E-:NMC-COVERAGE-CODE(4)					
	XXX	75	854	856	3
7 :E-:NMC-TPL-EFFECTIVE-DATES(4)					
	GROUP	76	857	872	16
10 :E-:NMC-TPL-START-DATE(4)					
	GROUP	77	857	864	8
15 :E-:NMC-TPL-YEAR-START(4)					
	X(4)	78	857	860	4
15 :E-:NMC-TPL-MONTH-START(4)					
	XX	79	861	862	2
15 :E-:NMC-TPL-DAY-START(4)					
	XX	80	863	864	2
10 :E-:NMC-TPL-END-DATE(4)					
	GROUP	81	865	872	8
15 :E-:NMC-TPL-YEAR-END(4)					
	X(4)	82	865	868	4
15 :E-:NMC-TPL-MONTH-END(4)					
	XX	83	869	870	2
15 :E-:NMC-TPL-DAY-END(4)					
	XX	84	871	872	2
5 :E-:NMC-TPL-TOTAL-TIMES	99	85	873	874	2
5 :E-:NMC-PREGNANCY-IND	X	86	875	875	1
5 :E-:NMC-EXPECTED-DATE-OF-BIRTH					
	GROUP	87	876	883	8
7 :E-:NMC-EXPECTED-DOB-YEAR					
	X(4)	88	876	879	4
7 :E-:NMC-EXPECTED-DOB-MONTH					
	XX	89	880	881	2
7 :E-:NMC-EXPECTED-DOB-DAY					
	XX	90	882	883	2
5 :E-:NMC-TRANSFER-REASON-CODE					
	XXX	91	884	886	3
5 :E-:NMC-PAE-PROGRAM-CODE					
	9(4)	92	887	890	4
5 :E-:NMC-RATE-GROUP	X(4)	93	891	894	4
5 :E-:NMC-CLIENT-COUNTY	99	94	895	896	2
5 :E-:NMC-SPI-CODE	X(01)	95	897	897	1
5 :E-:NMC-COPAY-IND	X(01)	96	898	898	1
5 FILLER	X(598)	97	899	1496	598
3 :E-:NMC-TRANSMIT-PLAN-NBR	9(4)	98	1497	1500	4

T RECORD - Client Eligibility Trailer Record

FIELD LEVEL/NAME	PICTURE	NUMBER	START	END	LENGTH
2 :E-:NMC-MEDICAID-ENROLL-TRL REDEFINES :E-:NMC-MEDICAID-ENROLL-HDR					
2 :E-:NMC-MEDICAID-ENROLL-TRL	GROUP	97	1	1500	1500
3 :E-:NMC-TRL-ACTION-TYPE	X	98	1	1	1
3 :E-:NMC-TRL-DATE-STAMP	GROUP	99	2	15	14
5 :E-:NMC-TRL-SYSTEM-DATE	GROUP	100	2	9	8
7 :E-:NMC-TRL-SYSTEM-YEAR	9(4)	101	2	5	4
7 :E-:NMC-TRL-SYSTEM-MONTH	99	102	6	7	2
7 :E-:NMC-TRL-SYSTEM-DAY	99	103	8	9	2
5 :E-:NMC-TRL-SYSTEM-TIME	GROUP	104	10	15	6
7 :E-:NMC-TRL-SYSTEM-HOUR	99	105	10	11	2
7 :E-:NMC-TRL-SYSTEM-MINUTE	99	106	12	13	2
7 :E-:NMC-TRL-SYSTEM-SECOND	99	107	14	15	2
3 :E-:NMC-TOTAL-DETAIL-RECORDS	9(7)	108	16	22	7
3 :E-:NMC-TOTAL-ENROLLED-CLIENT	9(7)	109	23	29	7
3 :E-:NMC-TOTAL-DIS-ENROLL-CLIENT	9(7)	110	30	36	7
3 :E-:NMC-TOTAL-TRANSFER-CLIENT	9(7)	111	37	43	7
3 :E-:NMC-TOTAL-CAP-AMTS-1	9(9)V99	112	44	54	11
3 :E-:NMC-TOTAL-CAP-AMTS-2	9(9)V99	113	55	65	11
3 :E-:NMC-TOTAL-CAP-AMTS-3	9(9)V99	114	66	76	11
3 :E-:NMC-TOTAL-CAP-AMTS-4	9(9)V99	115	77	87	11
3 :E-:NMC-TOTAL-CAP-AMTS-5	9(9)V99	116	88	98	11
3 :E-:NMC-TOTAL-CAP-AMTS-6	9(9)V99	117	99	109	11
3 :E-:FILLER	X(1387)	118	110	1496	1387
3 :E-:NMC-TRL-TRANSMIT-PLAN-NBR	9(4)	119	1497	1500	4

NEBRASKA MEDICAID MANAGED CARE

CLIENT ELIGIBILITY DATA

Document B: Health Plan Client Eligibility File Data Descriptive Notes

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY HEADER DATA RECORD - "H" RECORD

Field HHH Nebraska Managed Care Client Eligibility Header Record

Field Name: NMC-MEDICAID-ENROLL-HDR
Purpose: This is the Client Eligibility Header Data Record.
Valid Values: Follow.

Field H01 Header Action Type

Field Name: NMC-HDR-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'H'.

Field H02 Header Date/Time Stamp

Field Name: NMC-HDR-DATE-STAMP

NMC-HDR-SYSTEM-DATE	
NMC-HDR-SYSTEM-YEAR	PIC 9(04)
NMC-HDR-SYSTEM-MONTH	PIC 9(02)
NMC-HDR-SYSTEM-DAY	PIC 9(02)
NMC-HDR-SYSTEM-TIME	
NMC-HDR-SYSTEM-HOUR	PIC 9(02)
NMC-HDR-SYSTEM-MINUTE	PIC 9(02)
NMC-HDR-SYSTEM-SECOND	PIC 9(02)

Purpose: Each header record will contain the system date and time documenting when the file was created.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY DETAIL DATA RECORD - "D" RECORD

Field DDD Nebraska Managed Care Client Eligibility Detail Record

Field Name: NMC-MEDICAID-ENROLL-DET
Purpose: This is the Client Eligibility Detail Data Record.
Valid Values: Follow.

Field D01 Detail Action Type

Field Name: NMC- ACTION-TYPE PIC X.
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: X = Client Transfer occurred (same plan)
N = Client is newly eligible/enrolled for managed care
C = Client continues to be enrolled in managed care
D = Disenrolled Client

Field D02 Client Medicaid Identification Number

Field Name: NMC-CLIENT-MEDICAID-NBR.
NMC-MEDICAID-CASE-NBR PIC 9(09) VALUE 0.
NMC-CLIENT-CASE-ID PIC 9(02) VALUE 0.

Purpose: 11 digit Medicaid number assigned by the Health and Human Services to a person who has applied and is eligible for public assistance benefits. This number consists of a Medicaid case number and a client identification number within that case.
REQUIRED: YES
Valid Values: 11 digit Medicaid number.

Field D03 Client Social Security Number

Field Name: NMC-CLIENT-SSN PIC 9(09)
Purpose: This field contains the client's social security number.
REQUIRED: YES
Valid Values: Social security number of client, if a SSN is unknown or does not exist at the time of application, a temporary number which is the Arp number from NFOCUS, with the first digit replace by a '9'. The temporary number will be changed when a valid SSN is received from the SSA.

Field D04 Client Name

Field Name: NMC-CLIENT-NAME.

NMC-CLIENT-FNAME	PIC X(20).
NMC-CLIENT-MIDINIT	PIC X.
NMC-CLIENT-LNAME	PIC X(25).

Purpose: This field contains the client's first name, middle initial, and last name.
REQUIRED: YES

Field D05 Medical Plan Number

Field Name: NMC-MD-PLAN-NUMBER PIC 9(04)
Purpose: This field identifies the Med/Surg plan sending the provider file.
REQUIRED: YES
Valid Values: 2000 = UnitedHealthCare Community Plan
3000 = Aetna Better Health of Nebraska
4000 = Arbor Health Plan

Field D06 Provider Identification Number

Field Name: NMC-PROVIDER-NUMBER

NMC-MD-MEDICAID-PROV-NBR	PIC X(09).
NMC-MD-MEDICAID-PROV SFX	PIC 9(02)

Purpose: This field contains the 11 digit State of Nebraska Medicaid Number that identifies the provider at the location indicated in the record.
REQUIRED: YES
Valid Values: 11 digit Nebraska Medicaid Provider number assigned by Health and Human Services.
NMC-MD-MEDICAID-PROV-NBR must be numeric and greater than 0.
NMC-MD-MEDICAID-PROV-SFX must be 00, or a value greater than 0.

Field D07 Medical Medicaid Provider Terminated

Field Name: NMC-MD-MEDICAID-PROV-TERM PIC X
Purpose: This field contains an indicator of whether or not the provider is terminated with the medical health plan.
REQUIRED: NO
Valid Values: 'Y' or 'N'

Field D08 Vendor Provider Number

Field Name: NMC-VENDOR-PROV-NBR PIC X(15)
Purpose: This field contains the provider vendor identification number, as assigned by the medical health plan.
REQUIRED: NO
Valid Values: Any value other than spaces.

Field D09 Behavioral Health Plan Number

Field Name: NMC-BH-PLAN-NUMBER PIC 9(04)
Purpose: This field contains the BH plan number of the behavioral health plan that the client is enrolled with.
REQUIRED: NO
6000 = Magellan Behavioral Health

Field D10 Cap Rates

Field Name: NMC-CAP-RATES.

NMC-CAP-AMT1	PIC 9(05)V99	Prospective Cap Payment
NMC-CAP-AMT2	PIC 9(05)V99	Current Month Cap Payment
NMC-CAP-AMT3	PIC 9(05)V99	Not Used
NMC-CAP-AMT4	PIC 9(05)V99	Not Used
NMC-CAP-AMT5	PIC 9(05)V99	Not Used
NMC-CAP-AMT6	PIC 9(05)V99	Reinsurance Amount

Purpose: This field contains the amounts used for Capitation payments and calculations.
NMC-CAP-AMT1 contains the Medical / Surgical or behavioral health prospective cap payment.
NMC-CAP-AMT2 contains the cap payment for the clients who were immediately enrolled in current month.

NMC-CAP-AMT3, AMT4, AMT5 are not used.
NMC-CAP-AMT6 *contains the Reinsurance Amount, for reference only*.

REQUIRED: NO

Field D11 DSS Agency Code

Field Name: NMC-DSS-AGENCY-CODE.

NMC-DSS-DISTRICT	PIC 9(02).
NMC-DSS-ADM-OFFICE	PIC 9.
NMC-DSS-WORKER	PIC 9(02).

Purpose: This field contains the HHS office/worker that manages the client's case. Currently the district and administrative office values are used to distinguish medical vs. nonmedical Managed Care coverage areas.

REQUIRED: NO

Valid Values: First three digits a valid DSS agency code, last two a valid DSS worker code.

Field D12 Client Living Arrangement

Field Name: NMC-CLIENT-LIVING-ARRANGE PIC 9(02)

Purpose: This field contains a numeric code describing the client's living arrangements.

REQUIRED: NO

Valid Values:

- 01 - Apartment or House, Single Family House, House Arrest Community Service, Halfway House, House Arrest Work Release, Adoptive Home, Adult Day Home
- 03 - Homeless Shelter for Profit or Non Profit, Room Only, (Dorms, Sororities, Fraternities - Meals Not Provided, Hospital - Acute Hospital Care, Room Only - No Meals Provided, Job Corps, Military, Hospital
- 05 - Public Housing (not responsible for paying heating bills), (Dorms, Sororities, Fraternities - Meals Provided), Battered Women and Children Shelter - Non Profit, Temporary Lodging
- 06 - Public Housing, Pub Hsing - Multi-Fam Hse Not Responsible for Heating & Cooling Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Heating Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Cooling Bills, Multi-Family Dwelling, Adult Day Center, Adult Day Health Center
- 07 - Pub Hsing - Single Fam Hse Responsible for Heating Bills & Cooling Bills, Pub Hsing - Single Fam Hse Responsible for Heating Bills, Pub Hsing - Single Fam Hse Responsible for Cooling Bills, Child Care Center
- 09 - Board and Room, Chemical Dependency Treatment and Rehabilitation Center
- 10 - Licensed Mental Health Center, Licensed Domiciliary Facility, Assisted Living - Waiver
- 12 - Veterans Hospital/Veterans Nursing, Nursing Home/Long Term Care, Nursing Home
- 13 - Institution - Psychiatric Care – IMD, Psych Residential Treatment Facility

14 - Child Caring Agency, Child Caring Agency, Child Placing Agency, Emergency Shelter Center, Family Child Care Home I, Family Child Care Home II
17 - Licensed/Approved Foster Home, Emergency Shelter Foster Home, Foster Home, Foster Home - Agency Based, Foster Home - Child Specific, Foster Home - Relative
18 - Licensed Residential Care Facility, Assisted Living
19 - Licensed Center for Developmentally Disabled
20 - Certified Adult Family Home, Adult Family Home
30 - Group Home For Profit, Group Home - Institution Non-Profit Meals Provided, Boarder - Board And Rooms - Meals Provided, Incarceration, Residential Care, Preschool
32 - Boardinghouse - Commercial - Non-Profit, Boardinghouse - Commercial - For Profit, licensed Drug Treatment Center, Boarding Home
35 - Licensed/Approved Group Home For Children, Disabled Group Home - Non Profit - Meals Provided, Group Home, Group Home for Adults
36 - Institution for Mental Diseases (IMD)
37 - Correctional Facility

Field D13 Client Nationality

Field Name: NMC-CLIENT-NATIONALITY PIC X
Purpose: NOT USED
REQUIRED: NO

Field D14 Pregnancy related services Fee Indicator

Field Name: NMC-PREG-RELATED-SERV-IND PIC X.

Purpose: This field contains an indicator, stating that pregnancy-related services Capitation fee payment was made on behalf of an unborn or newborn child.
REQUIRED: NO

Valid Values: For NMC-PREG-RELATED-SERV-IND
Y - Capitation payment made for pregnancy-related services.
N - No Capitation payment made for pregnancy-related services.

Field D15 NMC Autoassignment Indicator

Field Name: NMC-AUTO-ASSIGN-IND PIC X.
Purpose: This field contains a code indicating if the client was autoassigned to the plan and provider.
REQUIRED: NO

Valid Values: Y - Yes, client was autoassigned.
N - No, client was not autoassigned.

Field D16 Client Cap Gender

Field Name: NMC-CAP-GENDER PIC X
Purpose: This field contains the gender used to determine the cap payment.
REQUIRED: NO
Valid Values: F - Female
M - Male
U - Unborn

Field D17 Special Needs Client Indicator

Field Name: NMC-SPECIAL-NEEDS-IND PIC X
Purpose: This field contains a code to define the special needs of a Client.
REQUIRED: NO
Valid Values: A – Children eighteen years of age and younger receiving SSI benefits
B – Children eighteen years of age and younger in Foster Care
C – Children eighteen years of age and younger receiving Title V services
D – Combined codes of A and B
E – Combined codes of A and C
F – Combined codes of B and C
G – Combined codes of A, B and C

Field D18 Reason for Clients Case Closing

Field Name: NMC-REASON-CLOSE-CODE PIC X(03).
Purpose: This field contains the code indicating why the client's case was closed.

REQUIRED: NO
Valid Values:
200 - Waiver of Enrollment
201 - Not Eligible for Medicaid Benefits
202 - Medicaid Status - Suspended or Closed
203 - Medicare
204 - Share of Cost
205 - Admitted to Long Term Care Facility
206 - Excluded group
207 - Excluded group
210 - Unknown County
211 - Admit to IMD or Correctional Facility
212 - Admit to PACE

Field D19 Lock In Code

Field Name: NMC-LOCK-IN-CODE PIC X
Purpose: This field contains the lock in code for what a client is locked in to.
REQUIRED: NO
Valid Values:
0 = No Lock-in
1 = One Pharmacy
2 = One Primary Practitioner and One Pharmacy
3 = One Primary Practitioner, One Pharmacy and One Hospital
4 = One Prescribing Physician and One Pharmacy
9 = Emergency Medical Services (Provider Number is given a value of 90000049999, and Licensed Doctor number is given a value of 2801 LOCK)

Field D20 Lock In Pharmacy Number

Field Name: NMC-LOCK-IN-PHARMACY PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a pharmacy.
REQUIRED: NO

Field D21 Lock In Primary Practitioner Number

Field Name: NMC-LOCK-IN-PRIM-PRACT PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a primary practitioner.
REQUIRED: NO

Field D22 Lock In License (Prescribing Physician Number)

Field Name: NMC-LOCK-IN-LICENSE PIC X(13)
Purpose: This field contains the 13 digit State of Nebraska Medicaid license number assigned to a prescribing physician.
REQUIRED: NO

Field D23 Lock In Hospital

Field Name: NMC-LOCK-IN-OP-HOSP PIC X(11)
Purpose: This field contains the 11 digit State of Nebraska Medicaid provider number assigned to a hospital.
REQUIRED: NO

Field D24 Fetal Number

Field Name: NMC-FETAL-NBR PIC 9(4)
Purpose: This field contains the number of fetuses of the pregnant mother.
REQUIRED: NO

Field D25 Mothers Name

Field Name: NMC-MOM-NAME.
NMC-MOM-FNAME PIC X(20).
NMC-MOM-MNAME PIC X.
NMC-MOM-LNAME PIC X(25).
Purpose: This field contains the name of the pregnant mother if client is an unborn or newborn.
REQUIRED: NO

TPL Information - the first four Current TPL's are sent

Field D26 Carrier Number

Field Name: NMC-CARRIER-NBR
NMC-CARRIER-CODE PIC X(05).
NMC-CARRIER-SEQ-NBR PIC X(03).
Purpose: These fields contain the code and the sequence number assigned to a commercial insurance company or third party administrative office that handles the processing and payment of health and casualty insurance claims.
REQUIRED: NO

Field D27 Carrier Name

Field Name: NMC-CARRIER-NAME PIC X(30).
Purpose: This field contains the name of the commercial insurance company or third party administrative office that handles the processing and payment of health and casualty insurance claims.
REQUIRED: NO

Field D28 Policy Key

Field Name: NMC-POLICY-KEY.
NMC-POLICY-NBR PIC X(20).
NMC-GROUP-NUMBER PIC X(20).
Purpose: These fields contain the policy key, which is the policy, number (the number assigned to clients policy) and the group number (the number given to the group plan that specifies the medical benefits provided through the health insurance plan).
REQUIRED: NO

Field D29 Subscriber Social Security Number

Field Name: NMC-SUBSCRIBER-SSN PIC X(09).
Purpose: This field contains the social security number of the owner of a commercial health insurance policy.
REQUIRED: NO

Field D30 Subscriber Name

Field Name: NMC-SUBSCRIBER-NAME.

	NMC-SUBSCR-FIRST	PIC X(20).
	NMC-SUBSCR-MIDINT	PIC X.
	NMC-SUBSCR-LAST	PIC X(25).

Purpose: These fields contain the name of the owner of a commercial health insurance policy.
REQUIRED: NO

Field D31 Relation Policy Holder

Field Name: NMC-RELATN-POLHLDR PIC X(02)
Purpose: This field contains a code that indicates the relation of the TPL.
REQUIRED: NO

10 - Self
11 - Spouse - policyholder living in the home eligible under another case number
12 - Spouse - policyholder living in home NOT eligible for Medicaid
13 - Spouse - policyholder NOT living in home - not legally separated or divorced
14 - Ex-spouse - policyholder NOT living in home - legally separated or divorced
15 - Friend - policy holder living in the home; may be common law arrangement or other like relationship
20 - Child - (natural or adoptive or step) - policyholder in home but not eligible for Medicaid
21 - Child - (natural or adoptive or step) - policyholder in home and eligible for Medicaid
22 - Child - (step) - policyholder NOT in the home
23 - Child - (natural or adoptive) - policyholder NOT in home (IVD referral)
30 - Foster Child - no legal obligation
31 - Grandchild - natural parent living in the home
32 - Grandchild - natural parent NOT living in the home
50 - Potential adoptive child - adoptive parents financially responsible
51 - Other - legally liable

Field D32 Coverage Code

Field Name: NMC-COVERAGE-CODE PIC X(03)
Purpose: This field contains the code that describes the coverage the client has.
REQUIRED: NO
Valid Values:

101 - MAJOR MEDICAL PLAN WITHOUT DENTAL; INCLUDES RX
120 - HMO PLAN WITHOUT DENTAL; INCLUDES RX
130 - MEDICARE SUPPLEMENT PLAN; EXCLUDES RX
140 - INPATIENT HOSPITAL AND RELATED SERVICES
149 - INPATIENT AND OUTPATIENT HOSPITAL AND RELATED SERVICES
150 - NURSING FACILITY CONFINEMENT PLAN
160 - PPO PLAN WITHOUT DENTAL; INCLUDES RX

Note: coverage is pending as policy has newly been identified and verification has not been received yet from the insurer to completely determine benefits.

201 - STANDARD MAJOR MEDICAL PLAN WITHOUT DENTAL; INCLUDES RX
202 - STANDARD MAJOR MEDICAL PLAN WITH DENTAL; EXCLUDES RX
203 - STANDARD MAJOR MEDICAL PLAN WITH DENTAL; INCLUDES RX
204 -STANDARD MAJOR MEDICAL PLAN WITHOUT DENTAL; EXCLUDES RX
208 -HEALTH INSURANCE FOR PAY & CHASE
301 -PPO OR HMO PLAN WITHOUT DENTAL; INCLUDES RX
302 -PPO OR HMO PLAN WITHOUT DENTAL; EXCLUDES RX
303 -PPO OR HMO PLAN WITH DENTAL; INCLUDES RX
304 -PPO OR HMO PLAN WITH DENTAL; EXCLUDES RX
375 -MEDICARE MANAGE CARE; EXCLUDES RX
401 -MEDICARE SUPPLEMENT TO PART A ONLY; EXCLUDES RX
402 -MEDICARE SUPPLEMENT TO PART B ONLY; EXCLUDES RX
403 - MEDICARE SUPPLEMENT TO PART A & B; EXCLUDES RX

404 -MEDICARE SUPPLEMENT WITH MAJOR MEDICAL; INCLUDES RX
405 -MEDICARE SUPPLEMENT TO PART A & B; EXCLUDES RX & PART B DEDUCTIBL
406 -MEDICARE SUPPLEMENT WITH MAJOR MEDICAL; INCLUDES NURSING HOME & R
407 -MEDICARE CARVE OUT PLAN; INCLUDES RX
500 -CHAMPUS/TRICARE OR CHAMPVA; INCLUDES RX
501 -IN AND OUTPATIENT HOSPITAL, INCLUDING ANCILLARY SERVICES
502 -IN AND OUTPATIENT HOSPITAL, PLUS ANCILLARY CHARGES; DUE TO ACCIDENT
531 -INPATIENT HOSPITAL, INCLUDING ANCILLARY CHARGES
532 -INPATIENT HOSPITAL AND ANCILLARY SERVICES RELATED TO AN ACCIDENT
533 -HOSPITAL INDEMNITY PLAN
534 -HOSPITAL INDEMNITY PLAN RELATED TO AN ACCIDENT
550 -DENTAL BENEFITS COVERAGE
551 - VISION BENEFITS COVERAGE
552 -PRESCRIPTION DRUG COVERAGE
553 -CHAMPUS/TRICARE OR CHAMPVA SUPPLEMENT POLICY
554 -VISION AND DENTAL BENEFITS COVERAGE
558 -PRESCRIPTION DRUG COVERAGE FOR PAY & CHASE
560 -CANCER BENEFITS POLICY
561 -SPECIFIED SERVICE POLICY
562 -DRUG CANCER BENEFITS POLICY
578 -NURSING HOME CONFINEMENT POLICY
600 -LIMITED BENEFITS POLICY

Note: Pay & Chase cases would include uncooperative non-custodial parent problem cases and/or insurance carriers not recognizing Medicaid regulations (requiring Legal Division assistance)that have been identified by TPL staff (all of these claims will edit in MCP165 to set Bypass Code - 'Z').

Field D33 Effective TPL Starting Date

Field Name: NMC-TPL-START-DATE.
NMC-TPL-YEAR-START PIC X(04).
NMC-TPL-MONTH-START PIC X(02).
NMC-TPL-DAY-START PIC X(02).
Purpose: These fields contain the starting date of clients TPL.
REQUIRED: NO

Field D34 Effective TPL Ending Date

Field Name: NMC-TPL-END-DATE.
NMC-TPL-YEAR-END PIC X(04).
NMC-TPL-MONTH-END PIC X(02).
NMC-TPL-DAY-END PIC X(02).
Purpose: These fields contain the ending date of clients TPL.
REQUIRED: NO

Field D35 TPL Total Times

Field Name: NMC-TPL-TOTAL-TIMES PIC 9(02)
Purpose: Indicates how many TPL policies the client has.
REQUIRED: NO

Field D36 Pregnancy Indicator

Field Name: NMC-PREGNANCY-IND PIC X.
Purpose: This field contains a code indicating if the client is known to be pregnant.
REQUIRED: NO

Valid Values: Y - Yes, client is pregnant.
N - No, we have no record of client being pregnant.

Field D37 Expected Date of Birth

Field Name: EXPECTED-DATE-OF-BIRTH.

EXPECTED-DOB-YEAR	PIC X(04).
EXPECTED-DOB-MONTH	PIC X(02).
EXPECTED-DOB-DAY	PIC X(02).

Purpose: This field contains the date the expected date of birth for an unborn child.
REQUIRED: NO

Field D38 Transfer Reason Code

Field Name: NMC-TRANSFER-REASON-CODE PIC X
Purpose: This field contains the code indicating why the client transferred.
REQUIRED: NO
Valid Values: 400 - AUTO ASSIGN-DIFFERENT PCP
401 - AUTO ASSIGN-DIFFERENT PLAN
402 - AUTO ASSIGN-EXISTING RELATIONSHIP W/ANOTHER PCP
404 - ACCESS-PCP WITH HISTORY NOT IN PLAN NETWORK
405 - ACCESS-SPECIALIST(S) WITH HX NOT IN PLAN NETWORK
406 - AUTO REENROLLMENT DURING OPEN ENROLL MONTH
407 - MOVE OUT OF MCO'S SERVICE AREA
410 - ACCESS-DISTANCE
412 - ACCESS-POOR PHYSICAL ACCESSIBLILTY FOR HANDICAPPED
413 - ACCESS-LANGUAGE BARRIER
414 - ACCESS-TOO LONG WAIT FOR APPOINTMENT
415 - ACCESS-DIFFICULT CONTACTING PCP
416 - ACCESS-LACK OF ACCESS TO COVERED SERVICES
420 - QUALITY-PROBLEM WITH EMERGENCY CARE
421 - DON'T LIKE PCP
422 - DON'T LIKE REFERRAL
424 - QUALITY - RECEIVED POOR CARE
425 - QUALITY - LONG WAITING ROOM LINE
426 - ACCESS - PCP REFUSED REFERRAL
427 - QUALITY - BETTER TREATED BY ANOTHER PCP
440 - ACCESS-INADEQUATE NETWORK
441 - QUALITY-SERVICE UNSATISFACTORY
450 - PCP REQUEST-CLIENT NON COMPLIANT
451 - PCP NO LONGER IN MC
452 - PCP REQUEST-ABUSE OF MC SERVICES
453 - REQUESTS DIFFERENT PCP LOCATION
454 - PCP NO LONGER IN PLAN
455 - PCP NO LONGER AT ADDRESS
456 - REQUESTED PCP NOW AVAILABLE
457 - PROVIDER ID CHANGE
458 - REQUESTED PCP NOT AVAILABLE/DIFFERENT PCP SELECTED
459 - PCP NOW HAS AVAILABLE SLOTS
460 - PCP HAS A SUSPENSION DATE/DIFFERENT PCP SELECTED
461 - ACCESS - PCP REFUSED TO SEE CLIENT

462 - INCORRECT LOCK-IN PCP
470 - CHOICE BASED ON PCP SPECIALITY
471 - PCP UNKNOWN TO CLIENT
472 - ACCESS-NEED BETTER ACCESS TO SPECIALIST
473 - WANT SAME PLAN FOR ENTIRE FAMILY
474 - ACCESS - WANT SAME PCP FOR ENTIRE FAMILY
480 - INTERIM PCP
485 - PLAN NO LONGER IN MC, NEW PLAN
488 - ACCESS-MORAL OR RELIGIOUS OBJECTION TO SERVICES
489 - RELATED SERVICES UNAVAILABLE
494 - PLAN REQUEST FOR TRANSFER APPROVED
498 - OTHER-PCP
499 - OTHER-PLAN

Field D39 PAE Program Code

Field Name: NMC-PAE-PROGRAM-CODE PIC X(04)
Purpose: This field contains the code for the public assistance in which the client is currently eligible to receive medical benefits
REQUIRED: YES
Valid Values:

PROGRAM CODE	*DESCRIPTION*
2001	ABD - ELDERY
2002	ABD - BLIND
2003	ABD - DISABLED
4004	AFDC-04
4005	AFDC-05
4090	Pregnant Women or 599 CHIP
6010	FC-HHS WARD
6020	FC-SUB GUARDIAN
6030	FC-HHS WARD
6031	FC-CRRCTNS WARD
6032	FC-HHS WARD
6033	FC-CRRCTNS WARD
6034	NON-HHS WARD
6040	NON-HHS WARD
6041	CORRECTIONS WARD
6042	NON-HHS WARD
6045	Presumptive Eligibility
6050	Ribicoff Medical Assistance
6051	FORMER HHS WARD
6055	MAC
6056	School Age Medical Assistance
6057	SCHOOL AGE MAC
6060	Subsidized Adoption Medicaid
6065	SCHOOL AGE MAC
6086	Subsidized Guardianship Title IV-E
6087	Subsidized Guardianship Non-IV-E
7800	PRESUMPT-HOSP
7810	NON-MAGI FFC
7820	MAGI INFANT
7830	MAGI PW
7840	MAGI CHILD 1-5
7850	MAGI CHILD 6-18
7860	MAGI CHIP

7870	MAGI PC-ABSENCE
7880	MAGI PC-DEATH
7890	MAGI PC-INCAP
7910	MAGI PC-UNEMP
7920	MAGI SCHIP
7930	MAGI FW
7940	MAGI IMD

Field D40 Rate Group

Field Name: NMC-RATE-GROUP PIC X(04)
Purpose: This field contains the code for the rate group for the client.
REQUIRED: YES
Valid Values: PHYSICAL HEALTH

AABD - Assistance to the Aged, Blind, Disabled, program grouping
FAM - Family program grouping
WARD - State foster care program grouping
CHIP - Kids Connection program grouping (same as KIDS)
KB - Katie Beckett

BEHAVIORAL HEALTH

BHAG - Behavioral health Aged program grouping
BHBD - Behavioral health Blind and Disabled program grouping
FAM - Family program grouping
WARD - State foster care program grouping
CHIP - Kids Connection program grouping (same as KIDS)
KB - Katie Beckett

Field D41 Client County

Field Name: NMC-CLIENT-COUNTY PIC 9(02)
Purpose: This field contains the numeric code identifying the Nebraska county in which the client resides.
REQUIRED: NO
Valid Values: COUNTY OF RESIDENCE

01 Adams	33 Furnas	65 Nuckolls
02 Antelope	34 Gage	66 Otoe
03 Arthur	35 Garden	67 Pawnee
04 Banner	36 Garfield	68 Perkins
05 Blaine	37 Gosper	69 Phelps
06 Boone	38 Grant	70 Pierce
07 Box Butte	39 Greely	71 Platte
08 Boyd	40 Hall	72 Polk
09 Brown	41 Hamilton	73 Red Willow
10 Buffalo	42 Harlan	74 Richardson
11 Burt	43 Hayes	75 Rock
12 Butler	44 Hitchcock	76 Saline
13 Cass	45 Holt	77 Sarpy
14 Cedar	46 Hooker	78 Saunders
15 Chase	47 Howard	79 Scotts Bluff
16 Cherry	48 Jefferson	80 Seward
17 Cheyenne	49 Johnson	81 Sheridan
18 Clay	50 Kearney	82 Sherman
19 Colfax	51 Keith	83 Sioux
20 Cuming	52 Keya Paha	84 Stanton
21 Custer	53 Kimball	85 Thayer
22 Dakota	54 Knox	86 Thomas

23 Dawes	55 Lancaster	87 Thurston
24 Dawson	56 Lincoln	88 Valley
25 Deuel	57 Logan	89 Washington
26 Dixon	58 Loup	90 Wayne
27 Dodge	59 Madison	91 Webster
28 Douglas	60 McPherson	92 Wheeler
29 Dundy	61 Merrick	93 York
30 Fillmore	62 Morrill	99 Out-of-State
31 Franklin	63 Nance	
32 Frontier	64 Nemaha	

Field D42 Special Program Indicator (SPI) codes

Field Name: NMC-SPI-CODE PIC X(01)
Purpose: This field contains the Special Program Indicator (SPI) codes.
REQUIRED: YES
Valid Values:

SPI Code	Description
A	Waiver Child DD (Prior to Jan 2003, included adult waiver)
B	MR Case Management Recipients
C	AABD Aged and Disabled Waiver Recipients
D	Waiver Children with Autism
E	AABD MA Only Recipients Using The 100% OMB Poverty Level
F	AABD Disabled Child Waiver Of Deeming Parental Income and Resources ('Katie Beckett' Cases)
G	Refugee Resettlement Clients
H	Aliens w/ Limited Medical Coverage
I	Early Intervention
K	CHIP
L	Breast / Cervical Cancer
M	Inmate of Public Institution
N	Not Currently Defined in N-FOCUS (EF Non-Employable)
O	Waiver Adult DD Comprehensive
P	Waiver Adult DD Residential
Q	Waiver Adult DD Day
R	Waiver Adult DD CSP
S	State (Permanent Legal Residents/UNDOC Immigrant Pregnant Women)
T	ADC/MA 12 Months Of Transitional Medical Assistance
U	Not Currently Defined in N-FOCUS (Previous Description: Indiv Exempt From Copayments. This code is only used for a Pregnant Woman Who Is Not Listed Under The Same Case Number As The Unborn)
V	Waiver TBI and Money Follows The Person
W	Waiver Traumatic Brain Injury (Effective Date: Oct. 2000)
X	Waiver A&D and Money Follows The Person
Y	Waiver Child DD and Money Follows The Person

Z	Waiver Adult DD Comprehensive and Money Follows The Person
1	MSP/QMB Medicare Crossover Only
BLANK	Recipient Is Not In A Medicaid Waiver Category

Field D43 Co-Pay Indicator

Field Name:	NMC-COPAY-IND	PIC X(01)
Purpose:	This field contains the Copay Indicator	
REQUIRED:	YES	
Valid Values:	0-INDIVIDUAL NOT SUBJECT TO COPAY	
	1-INDIVIDUAL SUBJECT TO COPAY	

NOTES FOR HEALTH PLAN CLIENT ELIGIBILITY TRAILER DATA RECORD - "T" RECORD

Field TTT Nebraska Managed Care Client Eligibility Trailer Record

Field Name: NMC-MEDICAID-ENROLL-TRL
Purpose: This is the Client Eligibility Trailer Data Record.
Valid Values: Follow.

Field T01 Trailer Action Type

Field Name: NMC-TRL-ACTION-TYPE PIC X
Purpose: This field contains the record type identifier.
REQUIRED: YES
Valid Values: The only valid value for this field is a 'T'.

Field T02 Trailer Date/Time Stamp

Field Name: NMC-TRL-DATE-STAMP
NMC-TRL-SYSTEM-DATE
NMC-TRL-SYSTEM-YEAR PIC 9(04)
NMC-TRL-SYSTEM-MONTH PIC 9(02)

```
                    NMC-TRL-SYSTEM-DAY          PIC 9(02)
               NMC-TRL-SYSTEM-TIME
                    NMC-TRL-SYSTEM-HOUR         PIC 9(02)
                    NMC-TRL-SYSTEM-MINUTE       PIC 9(02)
                    NMC-TRL-SYSTEM-SECOND       PIC 9(02)
```

Purpose: This field identifies the date and time that the plan sent the provider file.
REQUIRED: YES
Valid Values: Valid date in YYYYMMDD format.
Valid time in 24 hour HHMMSS format.

Field T03 Total Detail Records

Field Name: NMC-TRL-TOTAL-DETAIL-RECS PIC 9(07)
Purpose: This field contains an accumulated total count of the records in this batch. A batch is the group of records between the header and the trailer record.
REQUIRED: YES

Field T04 Total Enrolled Clients

Field Name: NMC-TOTAL-ENROLLED-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were enrolled.
REQUIRED: YES

Field T05 Total Dis-Enrolled Clients

Field Name: NMC-TOTAL-DIS-ENROLL-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were dis-enrolled.
REQUIRED: YES

Field T06 Total Transferred Clients

Field Name: NMC-TOTAL-TRANSFER-CLIENT PIC 9(07)
Purpose: This field contains an accumulated total count of the clients that were transferred.
REQUIRED: YES

Field T07 Total Capitation Amount 1

Field Name: NMC-TOTAL-CAPS-AMTS-1 PIC 9(07)
Purpose: This field contains an accumulated total count of fees or medical surgical or behavioral health prospective Capitation payments.
REQUIRED: YES

Field T08 Total Capitation Amount 2

Field Name: NMC-TOTAL-CAPS-AMTS-2 PIC 9(07)
Purpose: The field contains the total count of capitation payments for the clients who were immediately enrolled in current month.
REQUIRED: YES

Field T09 Total Capitation Amount 3

Field Name: NMC-TOTAL-CAPS-AMTS-3 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T10 Total Capitation Amount 4

Field Name: NMC-TOTAL-CAPS-AMTS-4 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T11 Total Capitation Amount 5

Field Name: NMC-TOTAL-CAPS-AMTS-5 PIC 9(07)
Purpose: NOT USED
REQUIRED: YES

Field T12 Total Capitation Amount 6

Field Name: NMC-TOTAL-CAPS-AMTS-6 PIC 9(07)
Purpose: This field contains an accumulated total count of reinsurance amounts.
REQUIRED: YES

Attachment 29 - Unit Definition for Category of Service

COS	Units
DME/Supplies	Claim Count
Emergency Room	Claim Count
Emergency Transportation	Claim Count
EPSDT	Claim Count
Family Planning	Claim Count
FQHC/RHC	Claim Count
Home Health	Days
Hospice	Days
Inpatient Hospital	Days
Lab and Radiology	Reported Units
Non-Emergency Transportation - Ambulance	Claim Count
Other Care	Claim Count
Other Professional	Claim Count
Outpatient Hospital	Claim Count
PCP	Claim Count
Specialist	Claim Count
Vision	Claim Count
Rx	Claim Count
Behavioral Health - IP	Days
Behavioral Health - OP	Reported Units
Behavioral Health - Residential	Reported Units
Behavioral Health - Other	Reported Units

Department of Health & Human Services
DHHS
NEBRASKA

RURAL HEALTH CLINIC RATES EFFECTIVE 07/01/2015

RHC FY2015 RATES			
Provider Name	**Provider #**	**Type**	
Edgar Satellite Clinic - PRHC	10025431100	23	$ 156.08
Blue Hill Clinic - PRHC	10025431300	23	$ 148.62
Avera Medical Group Verdigre - RHC	10025951100	23	$ 100.27
Avera Medical Group - Crofton PRHC	10026249100	23	$ 100.27
Avera Medical Group - Pierce PRHC	10026249200	23	$ 100.27
Avera Medical Group - Niobrara PRHC	10026249500	23	$ 100.27
Avera Medical Group - Hartington PRHC	10026249600	23	$ 100.27
Avera Medical Group - Laflan PRHC	10026323700	23	$ 100.27
Friend Medical Center - RHC	10025086100	20	$ 86.50
Lone Tree Medical Associates, PC - IRHC	10025126000	20	$ 90.62
Fillmore County Medical Center, PC - RHC	10025197500	20	$ 81.69
Saline Medical Specialities - IRHC	10025219200	20	$ 126.68
Bonesteel Medical Clinic - IRHC	10025312600	20	$ 105.52
Akron Mercy Medical Clinic - IRHC	10025463500	20	$ 86.26
Brady Rural Health Clinic - IRHC	10025533300	20	$ 91.49
Country Clinic, PC - IRHC	10025570200	20	$ 92.21
Country Clinics - Cedar Rapids - IRHC	10025570700	20	$ 92.21
Greater Sandhills Family Healthcare - IRHC	10025616100	20	$ 92.18
Greater Sandhills Family Healthcare - IRHC	10025616200	20	$ 92.18
Greater Sandhills Family Healthcare - IRHC	10025622300	20	$ 92.18
Regional West Physicians Clinic - IRHC - Morrill	10025713200	20	$ 120.35
Witter, Jo A. - IRHC	10025734500	20	$ 122.01
Ponca Mercy Medical Clinic - IRHC	10025783700	20	$ 102.99
Valentine Medical Clinic - RHC	10025859100	20	$ 139.18
Park Street Medical Clinic - IRHC	10025947900	20	$ 112.60
Family Medicine Clinic - IRHC	42095537920	20	$ 82.37
Medical Clinic - IRHC - Hamburg	42099401717	20	$ 83.72
Medical Clinic - IRHC - Sidney	42099401718	20	$ 83.72
Medical Clinic - IRHC - Tabor	42099401719	20	$ 83.72
Beemer Mercy Medical Clinic - IRHC	42128384930	20	$ 81.69
Pender Mercy Medical Clinic - IRHC	42128384931	20	$ 81.69
Bancroft Mercy Medical Clinic - IRHC	42128384932	20	$ 81.69
Emerson Mercy Medical Clinic - IRHC	42128384933	20	$ 81.69
Avera Medical Group - IRHC	46022474319	20	$ 99.00
Fairbury Clinic, PC - IRHC	47057349021	20	$ 77.36
Main Street Medical Clinic - IRHC	47064911100	20	$ 91.49
Burwell Family Practice - IRHC	47083890820	20	$ 146.17
	Statewide Average/Interim Rates		$ 100.20

In-State FQHC

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem	
100250243-00	17	70	28	55	PEOPLE'S HEALTH CENTER-FQHC	14023	1.008	$ 141.35	
100250761-00	17	70	28	71	GOOD NEIGHBOR COMM HLTH CTR - FQHC	12576	1.008	$ 126.77	
100255827-00	17	70	28	13	CASS FAMILY MEDICINE - FQHC	15001	1.008	$ 151.21	
100257047-00	17	70	28	59	MIDTOWN HEALTH CTR FQHC	12347	1.008	$ 124.46	
100257169-00	17	70	28	59	MIDTOWN HEALTH CENTER FQHC	12347	1.008	$ 124.46	
100258773-00	17	70	28	28	BENSON COMMUNITY HLTH CTR-FQHC-SB	15311	1.008	$ 154.33	
100259026-00	17	70	28	28	INDIAN HILLS ELEMENTARY-FQHC-SB	15001	1.008	$ 151.21	
100259028-00	17	70	28	28	SPRING LAKE ELEMENTARY-FQHC-SB	15001	1.008	$ 151.21	
100259030-00	17	70	28	28	LIBERTY ELEMENTARY-FQHC SB	15001	1.008	$ 151.21	
100262308-00	17	70	28	28	NORTHWEST HIGH SCHOOL - FQHC SB	15311	1.008	$ 154.33	
100262309-00	17	70	28	28	BELEVEDERE PUBLIC ELEMENTARY-FQHCSB	15311	1.008	$ 154.33	
100262310-00	17	70	28	28	KING SCIENCE & TECH MAGNET - FQHCSB	15311	1.008	$ 154.33	
100262311-00	17	70	28	28	KELLOM PUBLIC ELEMENTARY - FQHC SB	15311	1.008	$ 154.33	
100262747-00	17	70	28	28	CHARLES DREW HLTH CTR-CROWN FQHC	15311	1.008	$ 154.33	
100262749-00	17	70	28	28	CHARLES DREW HLTH CTR-EVANS FQHC	15311	1.008	$ 154.33	
100262761-00	17	70	28	28	CHARLES DREW HLTH CTR-JACKSON FQHC	15311	1.008	$ 154.33	
100262763-00	17	70	28	28	CHARLES DREW HLTH CTR-FLORENCE FQHC	15311	1.008	$ 154.33	
100262857-00	17	70	28	28	ONEWORLD COMM HLTH-LEAVENWORTH FQHC	15001	1.008	$ 151.21	
100262867-00	17	70	28	28	ONEWORLD COMM HLTH CTRS-NORTH FQHC	15001	1.008	$ 151.21	
100262868-00	17	70	28	28	ONEWORLD COMM HEALTH - SOUTH FQHC	15001	1.008	$ 151.21	
100262994-00	17	70	28	28	ONEWORLD COMM HLTH CTR - 120TH FQHC	15001	1.008	$ 151.21	
100263985-00	17	70	28	28	ONEWORLD COMM HEALTH CENTERS,INC	15001	1.008	$ 151.21	
100264170-00	17	70	28	28	ONEWORLD COMM HLTH CENTERS,INC FQHC	15001	1.008	$ 151.21	
470493594-10	17	70	28	79	COMM ACTION PARTNERSHP WEST NE-FQHC	13613	1.008	$ 137.22	
470548990-17	17	70	28	28	ONE WORLD COMMUNITY HEALTH CTR FQHC	15001	1.008	$ 151.21	
470666715-17	17	70	28	28	CHARLES DREW HLTH CTR FQHC	15311	1.008	$ 154.33	
470697260-17	17	70	28	55	NE URBAN INDIAN MEDICAL CTR FQHC	13474	1.008	$ 135.82	
								$ 148.03	Statewide Average as of 2-12-2015
								$ 148.03	

Out of State FQHC

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem
100250646-00	17	70	43	0	BENNETT COUNTY COMMUNITY HLTH FQHC	14002	1.008	$ 141.14
100256538-00	17	70	43	0	COMMUNITY HEALTH CLINIC - FQHC	14493	1.008	$ 146.09
100261217-00	17	70	43	0	SPRINGFIELD FAMILY CLINIC - FQHC	14271	1.008	$ 143.85
100263708-00	17	70	17	0	HEALTH PARTNERSHIP CLINIC-FQHC	16228	1.008	$ 163.58
421374894-10	17	70	16	0	SIOUXLAND COMMUNITY HLTH CTR FQHC	16420	1.008	$ 165.51
421466508-17	17	70	16	0	ALL CARE HEALTH CENTER-FQHC	16667	1.008	$ 168.00

PROVIDER #	TY	SP	ST	CN	PROVIDER NAME	Per Diem	MEI increase	New Per Diem	
100264329-00	17	70	17	0	HEALTH PARTNERSHIP CLINIC-FQHC			$ 148.03	This new FQHC should receive the Statewide Average for its initial year.

Attachment 26 - MLR and Risk Corridor Examples

Example 1. MCO pays money back to State under MLR and risk corridor

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,550
Net Qualified Medical Expenses divided by Earned Revenue		77.6%
Minimum MLR %		85.0%
Percentage below MLR		7.5%
MLR Reconciliation Payment	**$**	**(7,450)**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
MLR Rebate	$	(7,450)
Claims Incurred	$	75,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	77,550
Total Allowed Administration (Excluding HIT)	$	8,000
Profit/(Loss)	$	7,000
Risk Corridor Profit/(Loss) Share	**$**	**(4,000)**

Example 2. State pays money back to MCO under risk corridor

MLR Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,550
Net Qualified Medical Expenses divided by Earned Revenue		107.6%
Minimum MLR %		85.0%
Percentage below MLR		0.0%
MLR Reconciliation Payment	**$**	**-**

Risk Corridor Example		
Earned Revenue (Total Capitation Payments less hold-back and HIT)	$	100,000
MLR Rebate	$	-
Claims Incurred	$	105,000
Estimated IBNR	$	2,000
Medical Incentive Bonus	$	1,000
Reinsurance Premiums Less Recoveries	$	-
Activities that Improve Health Care Quality	$	50
Less Related-Party Medical Margin	$	(500)
Total Medical Expenses (Net Qualified Medical Expenses)	$	107,550
Total Allowed Administration (Excluding HIT)	$	8,000
Profit/(Loss)	$	(15,550)
Risk Corridor Profit/(Loss) Share	**$**	**12,550**

Attachment 25 - IBNR Assumptions by Source

	Physical Health Encounters				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.96	0.96	0.95	0.96	0.95
Emergency Room	0.95	0.96	0.95	0.96	0.97
Emergency Transportation	0.98	0.99	0.99	0.98	0.99
EPSDT	0.95	0.95	0.95	0.95	0.96
Family Planning	0.98	0.98	0.97	0.98	0.98
FQHC/RHC	0.95	0.96	0.96	0.97	0.97
Home Health	0.95	0.90	0.93	0.84	0.94
Hospice	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital	0.95	0.96	0.94	0.97	0.92
Lab and Radiology	0.93	0.94	0.93	0.96	0.96
Non-Emergency Transportation - Ambulance	0.99	0.99	0.99	0.99	0.99
Other Care	0.96	0.95	0.96	0.98	0.98
Other Professional	0.98	0.98	0.98	0.98	0.98
Outpatient Hospital	0.95	0.96	0.95	0.95	0.97
PCP	0.95	0.96	0.96	0.96	0.97
Specialist	0.97	0.97	0.97	0.97	0.98
Vision	0.97	0.98	0.97	0.97	0.98
Rx	N/A	N/A	N/A	N/A	N/A
Behavioral Health - IP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - OP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Residential	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Other	N/A	N/A	N/A	N/A	N/A

	Behavioral Health Encounters				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	N/A	N/A	N/A	N/A	N/A
Emergency Room	N/A	N/A	N/A	N/A	N/A
Emergency Transportation	N/A	N/A	N/A	N/A	N/A
EPSDT	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
FQHC/RHC	N/A	N/A	N/A	N/A	N/A
Home Health	N/A	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A	N/A
Inpatient Hospital	N/A	N/A	N/A	N/A	N/A
Lab and Radiology	N/A	N/A	N/A	N/A	N/A
Non-Emergency Transportation - Ambulance	N/A	N/A	N/A	N/A	N/A
Other Care	N/A	N/A	N/A	N/A	N/A
Other Professional	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital	N/A	N/A	N/A	N/A	N/A
PCP	N/A	N/A	N/A	N/A	N/A
Specialist	N/A	N/A	N/A	N/A	N/A
Vision	N/A	N/A	N/A	N/A	N/A
Rx	N/A	N/A	N/A	N/A	N/A
Behavioral Health - IP	0.93	0.93	0.89	0.96	N/A
Behavioral Health - OP	0.96	0.97	0.96	0.96	N/A
Behavioral Health - Residential	0.96	0.96	0.91	0.96	N/A
Behavioral Health - Other	0.94	0.98	0.95	0.97	N/A

Attachment 25 - IBNR Assumptions by Source

	FFS Data				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.99	N/A	N/A	0.99	1.00
Emergency Room	1.00	N/A	1.00	1.00	1.00
Emergency Transportation	1.00	N/A	N/A	1.00	1.00
EPSDT	1.00	N/A	N/A	1.00	N/A
Family Planning	1.00	N/A	N/A	1.00	1.00
FQHC/RHC	0.98	N/A	N/A	0.98	1.00
Home Health	1.00	N/A	0.99	1.00	N/A
Hospice	1.00	N/A	1.00	1.00	N/A
Inpatient Hospital	1.00	N/A	N/A	0.99	0.99
Lab and Radiology	1.00	N/A	1.00	1.00	1.00
Non-Emergency Transportation - Ambulance	0.99	N/A	N/A	1.00	N/A
Other Care	0.99	N/A	1.00	0.99	0.98
Other Professional	1.00	N/A	N/A	1.00	1.00
Outpatient Hospital	1.00	N/A	1.00	1.00	1.00
PCP	0.96	N/A	1.00	0.97	0.91
Specialist	1.00	N/A	N/A	1.00	1.00
Vision	0.96	N/A	N/A	0.98	1.00
Rx	1.00	1.00	1.00	1.00	N/A
Behavioral Health - IP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - OP	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Residential	N/A	N/A	N/A	N/A	N/A
Behavioral Health - Other	N/A	N/A	N/A	N/A	N/A

	Total				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	0.96	0.96	0.95	0.98	0.95
Emergency Room	0.95	0.96	0.95	0.97	0.97
Emergency Transportation	0.98	0.99	0.99	0.99	0.99
EPSDT	0.95	0.95	0.95	0.96	0.96
Family Planning	0.98	0.98	0.97	0.99	0.98
FQHC/RHC	0.96	0.96	0.96	0.98	0.97
Home Health	0.95	0.90	0.93	0.97	0.94
Hospice	1.00	N/A	1.00	1.00	N/A
Inpatient Hospital	0.95	0.96	0.94	0.98	0.92
Lab and Radiology	0.93	0.94	0.93	0.98	0.96
Non-Emergency Transportation - Ambulance	0.99	0.99	0.99	1.00	0.99
Other Care	0.96	0.95	0.96	0.98	0.98
Other Professional	0.98	0.98	0.98	0.98	0.98
Outpatient Hospital	0.95	0.96	0.95	0.96	0.97
PCP	0.95	0.96	0.96	0.96	0.97
Specialist	0.97	0.97	0.97	0.98	0.98
Vision	0.97	0.98	0.97	0.97	0.98
Rx	1.00	1.00	1.00	1.00	N/A
Behavioral Health - IP	0.93	0.93	0.89	0.96	N/A
Behavioral Health - OP	0.96	0.97	0.96	0.96	N/A
Behavioral Health - Residential	0.96	0.96	0.91	0.96	N/A
Behavioral Health - Other	0.94	0.98	0.95	0.97	N/A

Attachment 24 - NEMT - Ambulance Rates

	Rating Region 1			Rating Region 2		
COA	MMs	Addtl. Dollars	Addtl. PMPM	MMs	Addtl. Dollars	Addtl. PMPM
AABD 00-20 M&F	35,303	$ 13,616	$ 0.39	9,807	$ 192	$ 0.02
AABD 21+ M&F	106,576	$ 92,040	$ 0.86	27,407	$ 8,361	$ 0.31
AABD 21+ M&F-WWC	1,109	$ -	$ -	451	$ 115	$ 0.26
CHIP M&F	317,346	$ 9,644	$ 0.03	107,941	$ 3,771	$ 0.03
Family Under 1 M&F	106,184	$ 7,190	$ 0.07	32,855	$ 3,242	$ 0.10
Family 01-05 M&F	332,138	$ 6,643	$ 0.02	94,254	$ 4,549	$ 0.05
Family 06-20 F	284,805	$ 12,346	$ 0.04	82,972	$ 4,734	$ 0.06
Family 06-20 M	272,407	$ 9,490	$ 0.03	79,831	$ 2,996	$ 0.04
Family 21+ M&F	224,680	$ 24,670	$ 0.11	63,516	$ 7,359	$ 0.12
Foster Care M&F	82,203	$ 7,483	$ 0.09	22,223	$ 709	$ 0.03
Katie Beckett 00-18 M&F	412	$ -	$ -	412	$ -	$ -
Maternity	6,649	$ 11,567	$ 1.74	2,211	$ 10,274	$ 4.65

Attachment 23 - COS and COA Trends

	Rating Region 1 - Lower Bound				
	Annual PMPM Trend Rate				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	1.0%	1.7%	1.6%	1.3%	3.4%
Emergency Room	2.6%	2.7%	3.2%	2.3%	2.4%
Emergency Transportation	1.2%	1.7%	1.6%	1.3%	2.4%
EPSDT	1.4%	3.2%	1.4%	3.3%	2.4%
Family Planning	1.2%	1.7%	1.8%	1.3%	2.4%
FQHC/RHC	0.2%	1.7%	1.2%	2.3%	2.4%
Home Health	1.4%	1.7%	4.1%	1.3%	2.4%
Hospice	1.2%	0.0%	1.3%	1.3%	0.0%
Inpatient Hospital	1.1%	1.7%	3.9%	0.8%	3.4%
Lab and Radiology	1.2%	1.7%	2.2%	1.3%	1.9%
Non-Emergency Transportation - Ambulance	1.2%	1.7%	1.7%	1.3%	1.9%
Other Care	1.0%	1.7%	2.5%	2.3%	1.9%
Other Professional	2.6%	3.7%	2.8%	2.8%	4.0%
Outpatient Hospital	2.4%	1.7%	3.5%	1.8%	2.9%
PCP	1.6%	2.2%	1.5%	1.8%	2.9%
Specialist	1.1%	1.7%	3.1%	2.8%	2.4%
Vision	1.2%	1.7%	2.2%	1.8%	2.4%
Rx	7.0%	6.2%	6.5%	4.1%	N/A
Behavioral Health - IP	1.0%	0.5%	0.5%	-0.6%	N/A
Behavioral Health - OP	1.0%	1.0%	1.0%	0.9%	N/A
Behavioral Health - Residential	1.0%	1.4%	0.5%	0.0%	N/A
Behavioral Health - Other	0.3%	0.9%	0.8%	-0.1%	N/A

	Rating Region 2 - Lower Bound				
	Annual PMPM Trend Rate				
COS	AABD	CHIP	Family	Foster Care	Maternity
DME/Supplies	1.1%	1.5%	2.1%	0.9%	3.6%
Emergency Room	3.2%	3.5%	3.6%	1.9%	2.6%
Emergency Transportation	1.3%	1.5%	1.5%	0.9%	2.6%
EPSDT	1.5%	1.5%	1.4%	2.4%	2.6%
Family Planning	2.3%	1.5%	1.7%	0.9%	2.6%
FQHC/RHC	0.3%	2.5%	1.8%	0.4%	3.1%
Home Health	2.1%	2.5%	1.5%	0.9%	2.0%
Hospice	1.3%	0.0%	1.6%	0.0%	0.0%
Inpatient Hospital	1.6%	1.5%	4.3%	0.4%	3.6%
Lab and Radiology	2.7%	2.5%	3.2%	0.9%	2.0%
Non-Emergency Transportation - Ambulance	1.3%	1.5%	1.6%	0.9%	2.0%
Other Care	1.1%	3.0%	1.8%	1.9%	2.0%
Other Professional	1.1%	3.5%	2.8%	1.4%	2.0%
Outpatient Hospital	2.9%	2.0%	3.6%	1.4%	3.1%
PCP	1.1%	3.0%	1.9%	3.4%	3.1%
Specialist	1.2%	2.0%	3.1%	2.4%	2.6%
Vision	1.2%	1.5%	2.0%	1.4%	2.6%
Rx	7.4%	6.1%	6.6%	4.8%	N/A
Behavioral Health - IP	1.0%	0.5%	0.5%	-0.6%	N/A
Behavioral Health - OP	1.1%	1.0%	1.0%	0.9%	N/A
Behavioral Health - Residential	1.0%	1.4%	0.4%	0.0%	N/A
Behavioral Health - Other	0.3%	0.9%	0.7%	-0.1%	N/A

Heritage Health Rate Development Narrative

Background

The base data and adjustments used for the populations currently enrolled in Physical Health or Behavioral Health managed care were derived using the assumptions in the latest (January 2016 – June 2016) Physical Health and Behavioral Health rate development. For populations not currently enrolled in managed care FFS data was used, and rating adjustments from a comparable population were applied to create the projected rates. Optumas will update the base data and re-evaluate all assumptions when updating the Heritage Health rates in the spring.

Rating Regions

Optumas analyzed the cost differences (inclusive of the new populations and services) across counties and used the results of this analysis as the basis of the rating region recommendation for the Heritage Health program. After discussing the results of the regional analysis with the State, Optumas proposed Rating Region 1 (RR1) and Rating Region 2 (RR2) as outlined on page 142 of the RFP.

Covered Populations/Services

The populations and services that are included in the draft Heritage Health rates are illustrated in the "Heritage Health Pre-Proposal Conference" presentation.

Base Data

For the Physical Health acute care services, Optumas used SFY14 and SFY15 claims data from the existing Physical Health program, paid through September 30th, 2015.

For the Behavioral Health services, Optumas used claims data from the existing Behavioral Health program incurred from September 1st 2013 (the program's inception) through June 30th 2015. The Behavioral Health data for the Foster Care population was unique; Optumas only used SFY15 incurral dates. When analyzing the FY14 and FY15 Foster Care data, FY14 was substantially different than FY15 and Optumas determined that FY15 was the most reasonable basis for predicting future Foster Care expenses. The current managed care entity described the change in Foster Care experience as variance in utilization for PRTF due to a decrease in requests for PRTF. After further discussions, it was determined that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns. The Behavioral Health data was paid through June 30th 2015.

For the populations and services that are being carved into Managed Care, such as the Pharmacy benefit or the acute care services for the LTSS population, Optumas used SFY14 and SFY15 FFS data, paid through September 30th, 2015.

Figure 1. Data Sources

Populations	Services	Data Source
Populations currently enrolled in Physical Health Managed Care	Physical Health and Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entities

Populations	Services	Data Source
LTSS Population	Physical Health Services	SFY14 and SFY15 FFS data
LTSS Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Non-LTSS Dual Population	Physical Health Services	SFY14 and SFY15 FFS data
Non-LTSS Dual Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Subsidized Adoption Population	Physical Health Services	SFY14 and SFY15 FFS data
Subsidized Adoption Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Women with Cancer Population	Physical Health Services	SFY14 and SFY15 FFS data
Women with Cancer Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Hospice Population	Physical Health Services	SFY14 and SFY15 FFS data
Hospice Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
All Populations	Rx and Transplant Services	SFY14 and SFY15 FFS data

IBNR

Optumas analyzed the claim payment lag by category of service through the incurred but not reported (IBNR) analysis. IBNR factors were developed and applied to the base data by category of service and data source. Completion patterns and assumptions for encounter data sets were discussed with current managed care entities to ensure reasonableness. IBNR factors can be found in the accompanying Excel document, titled “IBNR Assumptions by Source”.

Program Changes

The State has implemented several program and policy changes that impacted the service costs that were not reflected in the base data. Optumas considered any prospective program change adjustments necessary to project the base to the contract period. Optumas and the State worked in partnership to determine the impact, shown within Figure 2 below, of the program changes on the projected capitation rate ranges:

Figure 2. Program Changes

Adjustment	Overview
ASD Adjustment	Beginning October 2015, the State is requiring the coverage of applied behavior analysis (ABA) and Behavioral Modification services for children with an Autism Spectrum Disorder (ASD) diagnoses. The State provided Optumas with the prevalence of ASD, which equated to 0.6% of Medicaid children having an ASD diagnosis. Optumas used this prevalence information, coupled with research and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
DD Adjustment	Beginning October 2015, the State is requiring coverage of ABA and Behavioral Modification services for children with a Developmental Disability (including Intellectual Disability) (DD). The State provided Optumas with the prevalence of DD, which equated to 0.7% of Medicaid children having a Development Disability. Optumas used this prevalence information and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
Service Delivery Adjustments	NEMT Ambulance – This adjustment represents the addition of NEMT Ambulance services to the Managed Care program. Rx Dispensing Fee Change – This adjustment represents a change in the dispensing fee for non-independent pharmacies, from $4.45 to $2.50. Dual Integrated Care Savings - Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of need duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to the healthy dual population is a reduction of 5.4%.
Immediate Enrollment	Beginning February 1, 2014, the State has implemented immediate enrollment in Medicaid managed care for newly eligible members. Enrollment is now effective back to the first day of the month that a health plan is chosen. Previously enrollment was effective the first day of the month following health plan selection. The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that

Adjustment	Overview
	period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the Physical Health managed care program after the policy was implemented. This adjustment is somewhat mitigated because it is inherent in 17 of the 24 months of base data.
APR-DRG	On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. Optumas then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO. The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the impact is close to budget neutral in aggregate but does show increases and decreases by rate cell.
FQHC Rate Updates	Optumas calculated and applied an adjustment to account for FQHC APM rate changes. Optumas adjusted the FQHC rates inherent in the encounter data to be commensurate with the FQHC APM rates effective 1/1/16.
Prospective Behavioral Health Provider Increase	Beginning July 2014 and July 2015, the State has implemented a 2.25% provider increase. Optumas applied the 2.25% increase to all Behavioral Health services, with the exception of FQHC and RHC providers. The September-June 2014 data received three and a half 2.25% increases, while the July-June 2015 data received two and a half 2.25% increase.

Adjustment	Overview
PRTF Program Change	Optumas calculated and applied an adjustment to account for cost settlements made outside of the MMIS system to two Psychiatric Residential Treatment Facilities. Optumas adjusted the PRTF rates inherent in the encounter data to be commensurate with these cost settlements.
MST/FFT Carve-In	Effective July of 2016 Multisystematic Therapy (MST) and Functional Family Therapy (FFT) will be covered benefits. Optumas added the anticipated expense for these services into the Heritage Health rates. The expense was projected using provider information, case rates, and anticipated provider caseloads. Optumas developed these assumptions with the help of our internal clinician.
Behavioral Health Copay Adjustment	Beginning January 2014, the State implemented a $2.00 copay for certain services. Since this change was implemented within the base data period, Optumas only needed to adjust September-December 2013 to reflect the copay policy change. The January 2014 – June 2015 base data already reflected the copay implementation, so no adjustment for this time period was necessary.
Physical Health Copay Adjustment	The State currently imposes copays on several Medicaid populations. While MCOs are not required to charge copays, the State reimburses the MCOs as if they did impose copays. The impact of this program change was calculated by adjusting reimbursement as necessary to reflect full collection of copays.
Benefit Limits	The State currently imposes limits on chiropractic visits, rehab visits, hearing aids, and eyeglasses for Medicaid FFS. The impact of this program change was calculated by removing any utilization and corresponding cost from the SFY14-15 base data for any of the services listed above that exceeded the FFS utilization limit.

Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major category of service (COS) (e.g., inpatient, outpatient, etc.) and category of aid (e.g. AABD, Family, etc.). Trend values can be found in the accompanying Excel file, titled “COS and COA Trends”.

Physical Health and Pharmacy trends were applied for a total of 36 months from the midpoint of the July 2013 – June 2015 base (6/30/2014) to the midpoint of the contract period (7/2/2017).

With the exception of Foster Care, Behavioral Health trends were applied for a total of 35 months from the midpoint of the September 2013 – June 2015 base (7/31/2014) to the midpoint of the contract period (7/2/2017). Foster Care trends were applied for a total of 30 months from the midpoint of the July 2014 – June 2015 base (12/30/2014) to the midpoint of the contract period (7/2/2017).

Non-Medical Loading

The non-medical load measures the dollars associated with components such as administration, profit, and quality improvement (QI) and are expressed as a percentage of the capitation rate. Optumas utilized reported administrative and profit levels in the financials submitted by the current managed care entities to develop the non-medical load. Experience in other states and similar programs on both a PMPM and percentage basis were also reviewed to ensure reasonableness.

Nebraska State Statue 78-831 requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the Department on or after July 1, 2012, shall:

> (1) Provide a definition and cap on administrative spending that (a) shall not exceed 7% unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed 10%.

The detailed non-medical loading assumption by each subcategory is included in slide 15 of the rate presentation.

UNMC Supplemental Payment

The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. Since the MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then paid by the MCOs to UNMC.

Optumas received a list of UNMC provider IDs from the State as well as the MCOs. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.

Attachment 21 - Non-Medical Load Assumption

	Rating Region 1			
	Lower Bound			
COA	**Admin/QI**	**Perf. Guarantee**	**Profit/Risk/Contingency**	**Total NML**
AABD 00-20 M&F	9.49%	0.25%	2.00%	11.74%
AABD 21+ M&F	9.57%	0.25%	2.00%	11.82%
AABD 21+ M&F-WWC	9.41%	0.25%	2.00%	11.66%
CHIP M&F	12.25%	0.25%	2.00%	14.50%
Family Under 1 M&F	8.50%	0.25%	2.00%	10.75%
Family 01-05 M&F	12.11%	0.25%	2.00%	14.36%
Family 06-20 F	12.33%	0.25%	2.00%	14.58%
Family 06-20 M	12.34%	0.25%	2.00%	14.59%
Family 21+ M&F	12.18%	0.25%	2.00%	14.43%
Foster Care M&F	9.01%	0.25%	2.00%	11.26%
Katie Beckett 00-18 M&F	0.65%	0.25%	2.00%	2.90%
Maternity	0.65%	0.25%	2.00%	2.90%

	Rating Region 2			
	Lower Bound			
COA	**Admin/QI**	**Perf. Guarantee**	**Profit/Risk/Contingency**	**Total NML**
AABD 00-20 M&F	9.46%	0.25%	2.00%	11.71%
AABD 21+ M&F	9.51%	0.25%	2.00%	11.76%
AABD 21+ M&F-WWC	9.38%	0.25%	2.00%	11.63%
CHIP M&F	12.22%	0.25%	2.00%	14.47%
Family Under 1 M&F	8.50%	0.25%	2.00%	10.75%
Family 01-05 M&F	12.09%	0.25%	2.00%	14.34%
Family 06-20 F	12.31%	0.25%	2.00%	14.56%
Family 06-20 M	12.35%	0.25%	2.00%	14.60%
Family 21+ M&F	12.18%	0.25%	2.00%	14.43%
Foster Care M&F	8.89%	0.25%	2.00%	11.14%
Katie Beckett 00-18 M&F	0.65%	0.25%	2.00%	2.90%
Maternity	0.65%	0.25%	2.00%	2.90%

Attachment 20 - COA-level Rate Development

	Rating Region 1													
	Base PMPM	Policy Changes	Adj. PMPM	ASD Adjustment	Adj. PMPM	DD Adjustment	Adj. PMPM	Immediate Enrollm	Adj. PMPM	Service Delivery A	Adj. PMPM	Annual PMPM Trend	Effective Trend Days	Final Medical Rate
AABD 00-20 M&F	$ 884.24	1.3%	$ 895.78	2.8%	$ 920.85	2.8%	$ 946.72	0.2%	$ 948.25	-0.2%	$ 946.24	1.0%	1,094	$ 976.29
AABD 21+ M&F	$ 1,262.51	0.5%	$ 1,268.58	0.0%	$ 1,268.58	0.0%	$ 1,268.58	0.2%	$ 1,270.85	-0.4%	$ 1,266.26	3.6%	1,094	$ 1,406.62
AABD 21+ M&F-WWC	$ 2,075.13	0.1%	$ 2,077.51	0.0%	$ 2,077.51	0.0%	$ 2,077.51	0.0%	$ 2,077.51	-0.2%	$ 2,072.48	2.0%	1,097	$ 2,201.95
CHIP M&F	$ 136.26	1.7%	$ 138.56	1.1%	$ 140.02	0.9%	$ 141.35	0.3%	$ 141.81	-0.4%	$ 141.23	3.2%	1,093	$ 155.04
Family Under 1 M&F	$ 405.53	0.7%	$ 408.24	0.0%	$ 408.24	0.0%	$ 408.24	2.7%	$ 419.14	-0.2%	$ 418.49	3.3%	1,097	$ 460.76
Family 01-05 M&F	$ 115.03	1.4%	$ 116.63	2.9%	$ 119.99	0.6%	$ 120.72	0.5%	$ 121.31	-0.4%	$ 120.78	2.3%	1,095	$ 129.13
Family 06-20 F	$ 131.16	2.1%	$ 133.92	0.7%	$ 134.87	1.1%	$ 136.38	0.3%	$ 136.84	-0.5%	$ 136.21	3.3%	1,092	$ 149.92
Family 06-20 M	$ 140.09	2.2%	$ 143.17	0.7%	$ 144.17	1.1%	$ 145.72	0.2%	$ 146.08	-0.4%	$ 145.45	3.7%	1,092	$ 161.93
Family 21+ M&F	$ 334.76	0.8%	$ 337.40	0.0%	$ 337.40	0.0%	$ 337.40	0.1%	$ 337.82	-0.6%	$ 335.78	3.9%	1,095	$ 377.16
Foster Care M&F	$ 396.57	2.7%	$ 407.08	3.0%	$ 419.23	2.1%	$ 427.84	0.1%	$ 428.46	-0.4%	$ 426.96	2.0%	1,037	$ 452.29
Katie Beckett 00-18 M&F	$ 11,797.62	-0.1%	$ 11,780.66	0.4%	$ 11,822.88	0.2%	$ 11,848.08	0.2%	$ 11,871.98	0.0%	$ 11,867.85	2.2%	1,097	$ 12,654.24
Maternity	$ 6,854.49	0.3%	$ 6,872.60	0.0%	$ 6,872.60	0.0%	$ 6,872.60	1.8%	$ 6,996.59	0.0%	$ 6,998.17	3.2%	1,098	$ 7,687.83
Dual Instituational	$ 208.41	0.9%	$ 210.26	0.0%	$ 210.26	0.0%	$ 210.28	0.3%	$ 210.87	0.0%	$ 210.87	3.0%	1,092	$ 230.31
Non-Dual Institutional	$ 2,606.23	-0.6%	$ 2,590.57	0.0%	$ 2,590.76	0.3%	$ 2,598.94	0.2%	$ 2,604.62	1.1%	$ 2,632.33	3.0%	1,093	$ 2,876.09
Dual HCBS	$ 249.48	0.9%	$ 251.65	0.0%	$ 251.65	0.1%	$ 251.93	0.3%	$ 252.63	0.0%	$ 252.63	2.4%	1,091	$ 271.09
Non-Dual HCBS	$ 1,280.79	0.1%	$ 1,282.24	0.1%	$ 1,283.11	3.1%	$ 1,323.01	0.2%	$ 1,325.28	-0.3%	$ 1,321.19	3.5%	1,092	$ 1,465.82
Dual	$ 271.91	2.4%	$ 278.32	0.0%	$ 278.32	0.0%	$ 278.32	0.2%	$ 278.93	-4.9%	$ 265.12	2.2%	1,085	$ 282.66

	Rating Region 2													
	Base PMPM	Policy Changes	Adj. PMPM	Immediate Enrollment	Adj. PMPM	Service Delivery Adjustment	Adj. PMPM	ASD Adjustment	Adj. PMPM	DD Adjustment	Adj. PMPM	Annual PMPM Trend	Effective Trend Months	Final Medical Rate
AABD 00-20 M&F	$ 1,005.20	0.6%	$ 1,011.22	0.2%	$ 1,012.75	-0.2%	$ 1,010.73	1.8%	$ 1,028.69	1.9%	$ 1,048.39	2.3%	1,095	$ 1,123.17
AABD 21+ M&F	$ 1,390.26	0.4%	$ 1,396.47	0.2%	$ 1,398.94	-0.3%	$ 1,395.22	0.0%	$ 1,395.22	0.0%	$ 1,395.22	4.1%	1,095	$ 1,571.78
AABD 21+ M&F-WWC	$ 2,357.86	0.0%	$ 2,357.99	0.0%	$ 2,357.99	-0.2%	$ 2,353.63	0.0%	$ 2,353.63	0.0%	$ 2,353.63	2.5%	1,097	$ 2,532.75
CHIP M&F	$ 135.71	0.9%	$ 136.98	0.4%	$ 137.47	-0.3%	$ 137.06	0.8%	$ 138.17	0.8%	$ 139.28	3.3%	1,094	$ 153.32
Family Under 1 M&F	$ 364.07	0.1%	$ 364.61	2.7%	$ 374.38	-0.1%	$ 373.89	0.0%	$ 373.89	0.0%	$ 373.89	3.4%	1,097	$ 413.76
Family 01-05 M&F	$ 122.05	0.5%	$ 122.67	0.5%	$ 123.29	-0.3%	$ 122.86	2.2%	$ 125.54	0.5%	$ 126.14	2.8%	1,096	$ 137.24
Family 06-20 F	$ 139.67	1.8%	$ 142.19	0.4%	$ 142.71	-0.3%	$ 142.23	0.5%	$ 142.96	0.9%	$ 144.21	3.3%	1,093	$ 158.84
Family 06-20 M	$ 143.31	2.5%	$ 146.92	0.3%	$ 147.31	-0.3%	$ 146.83	0.5%	$ 147.62	0.9%	$ 148.91	3.4%	1,092	$ 164.67
Family 21+ M&F	$ 404.79	0.6%	$ 407.33	0.1%	$ 407.84	-0.4%	$ 406.38	0.0%	$ 406.38	0.0%	$ 406.38	4.3%	1,095	$ 461.18
Foster Care M&F	$ 361.97	2.3%	$ 370.15	0.1%	$ 370.67	-0.3%	$ 369.70	2.4%	$ 378.46	1.7%	$ 384.98	2.7%	1,050	$ 415.70
Katie Beckett 00-18 M&F	$ 11,797.62	-0.1%	$ 11,780.66	0.2%	$ 11,804.42	0.0%	$ 11,800.31	0.4%	$ 11,842.60	0.2%	$ 11,867.85	2.2%	1,098	$ 12,654.24
Maternity	$ 6,678.14	0.3%	$ 6,694.97	1.8%	$ 6,818.26	0.1%	$ 6,822.50	0.0%	$ 6,822.50	0.0%	$ 6,822.50	3.2%	1,098	$ 7,504.02
Dual Instituational	$ 175.60	0.6%	$ 176.59	0.3%	$ 177.09	0.0%	$ 177.09	0.0%	$ 177.09	0.0%	$ 177.12	3.3%	1,092	$ 195.31
Non-Dual Institutional	$ 1,744.00	0.0%	$ 1,743.37	0.2%	$ 1,746.56	-0.1%	$ 1,745.47	0.0%	$ 1,745.49	0.8%	$ 1,758.74	3.9%	1,093	$ 1,974.47
Dual HCBS	$ 225.60	0.7%	$ 227.08	0.3%	$ 227.72	0.0%	$ 227.72	0.0%	$ 227.72	0.0%	$ 227.79	2.8%	1,092	$ 247.43
Non-Dual HCBS	$ 1,173.85	0.3%	$ 1,177.31	0.2%	$ 1,179.54	-0.2%	$ 1,177.36	0.0%	$ 1,177.72	2.5%	$ 1,207.31	3.6%	1,092	$ 1,340.45
Dual	$ 233.52	1.8%	$ 237.72	0.2%	$ 238.28	-6.9%	$ 221.81	0.0%	$ 221.81	0.0%	$ 221.81	2.6%	1,087	$ 239.11

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM SEVEN
QUESTIONS and ANSWERS

Date: November 19, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

The following are the responses to Questions 221 – 382 for the first round of questions.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
221.	IV. P.8-13 MCO Reimbursement	145	"Please provide a few detailed numerical examples to demonstrate the timing and order of calculation of the following adjustments/ limitations to capitation revenue, and how they are applied and interact with each other. In parentheses, we have shown our understanding of some of the specifics of these calculations: 1) Risk Adjustment (begins 7/1/2017, calculated annually? for each rating period? calculated by category of aid and region, for selected categories of aid) 2) Minimum MLR (begins on contract start date?, calculated annually on a six to nine month lag, for program in total) 3) Risk Corridor (begins on contract start date?, calculated annually on a nine month lag, for program in total) 4) MLTC Quality Performance Program (effective contract	The application of risk scores will not begin until the second contract period, 1/1/18-12/31/18. The State and its contracted actuary will work together in determining the best risk adjustment methodology to use at that time. The Minimum MLR will be in effect beginning on the contract start date and will be calculated on an annual basis between 6-9 months after the end of the contract year. Although the MLR will be settled annually, as mentioned in Attachment 15 “the MCO must calculate the MLR and submit it to MLTC quarterly”. The 85% Minimum MLR requirement will be calculate as an aggregate of Regions 1 and 2 and will be calculated across all categories of aid. The risk corridor will be in effect beginning on the contract start date and will be calculated at the end of each contract period between 6-9 months after the end of the contract year. The risk corridor calculation will be an aggregate of Regions 1 and 2 across all categories of aid. The administrative cap requirement is built into the capitation rates on a prospective basis. The contracted actuary ensured that the amount of non-medical load built into the rates meets the administrative cap requirement. The UNMC amount built into the capitation rates will remain the same throughout the entire contract period. The contracted actuary developed the UNMC Supplemental PMPM by COA, COS, and Rating Region. MLTC Quality Performance Program and Performance Penalities are effective Year 1 and calculated annually on a 6 – 9 month lag for program end total. Attachment 26:“MLR and Risk Corridor Examples” contains an illustrative example of this scenario. Please see Section IV.P.9.d-e.

			start date, calculated annually on a six month lag, for program in total) 5) State Performance Penalties (effective in contract year one, with metrics provided before year two, calculated annually 6) Administrative Cap (begins on contract start date?, calculated annually on a nine month lag, for program in total) 7) UNMC Supplemental Payments (begins on contract start date? calculated into the capitation rate on a quarterly basis, separate payments by category of aid and region) In particular, please ensure that these examples illuminate the answers to the questions in parentheses and demonstrate all of the calculations that would result in each of the following situations: 1) MCOs rebate to the state under the MLR, 2) MCOs deposit into the reinvestment accounts under	

			the risk corridor and the MLTC quality program 3) MCOs receive money back from the state under the risk corridor"	
222.	Attachment 15	Attachment 15 and page xiii	Attachment 15, Medical Loss Ratio Requirements, defines Net Qualified Medical Expense (the numerator in the MLR calculation) as follows: the sum of: a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries e. Activities that improve health care quality, per 45 CFR 158.150 f. Less related-party medical margin Whereas, page xiii defines Medical Loss Ratio as: The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for	Confirmed. Item 4 under the MLR Calculation section of Attachment 15 defines “allowable QI expenses”.

			members and allowable QI expenses under this contract. For purposes of the MLR calculation, are "allowable QI expenses"" those as defined in the definition of Net Qualified Medical Expense in Attachment 15?"	
223.	Attachment 15	All	Please provide numerical examples of how related party medical margin is to be included in the calculation of Net Qualified Medical Expenses.	If a related party subcontractor was paid premiums of $100 by the MCO and had expenses of $75, an amount of $25 would be deducted from the Net Qualified Medical Expense calculation.
224.	Attachment 15	All	Please provide numerical examples of how affiliate/related party underwriting losses/gains on reinsurance are to be included in the calculation of Net Qualified Medical Expenses, which is defined in Attachment 15 as follows: the sum of: a. Claims incurred b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense c. Medical incentive bonuses d. Reinsurance premiums less reinsurance recoveries	Yes, these examples are correct.

			e. Activities that improve health care quality, per 45 CFR 158.150 f. Less related-party medical margin For example, if a related party reinsurer was paid reinsurance premiums of $100 by the MCO and had incurred reinsurance underwriting losses of $120 paid to the MCO, would losses of $20 be included as a subtraction in item d. in the calculation above, then added back for positive $20 in item f., since under this scenario the related party reinsurer had an underwriting loss of $20? Conversely, if a related party reinsurer was paid reinsurance premiums of $100 by the MCO and had incurred reinsurance underwriting losses of $75 paid to the MCO, presumably an amount of $25 would be added in item d. of the calculation and an amount of $25 would be deducted in item f. of the calculation. Is this correct?"	

225.	Glossary of Terms	xiv	Within the definition of Non-Quality Improvement Administrative Expenses (definition from glossary pasted below), as it relates to item 1., Direct Administration, please comment as to whether the use of the term ""medical management"" is for costs that do not meet the definition of activities that improve health care quality per 45 CFR 158.150. Said differently, please confirm that costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of ""direct administration"" as used in defining Non-Quality Improvement Administrative Expenses. Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses	Costs that meet the definition of improving health care quality per 45 CFR 158.150 are not included in the definition of “direct administration”.

			include: 1. Direct administration: customer service, enrollment, medical management, claims administration, etc. 2. Indirect administration: accounting, actuarial, legal, human resources, etc. 3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded."	
226.	IV.P.12 and Attachment 15	147 & Attachment 15	Is the definition of "quality improvement" administrative costs that are allowed to be included up to 3% in the determination of the MCO's administrative cap the same definition as "activities that improve health care quality per 45 CFR 158.150" as those are included in the numerator in the calculation of the MLR? We recognize there is the 3% limit for the Administrative Cap and there is not a specified limit for purposes of the MLR; in this question we are inquiring as to the consistency of the definition (not extent) of the	See response to Question # 178.

			quality improvement costs.	
227.	IV. P.8-13 MCO Reimbursement	145	"Please provide an explanation as to why there is different treatment of the MLTC Quality Performance hold-back within each of the following calculations: 1) Minimum MLR (earned holdback not factored into the calculation) 2) Risk Corridor (earned holdback not factored into the calculation) 3) Administrative Cap (earned and forfeited holdback is factored into the calculation) For example, by ""is factored in"" do you mean that these amounts are added back in to the calculation for the Administrative Cap? Similarly, is forfeited holdback factored into the calculation of Minimum MLR and Risk Corridor? Also, please explain how the State Performance Penalties are factored into each of the above calculations."	The MLTC Quality Performance hold-back is not factored into the risk corridor or the Minimum MLR. The MLTC Quality Performance hold-back is factored in to the Administrative Cap. It is required to be factored in to the administrative cap so that if an MCO earns the entire hold-back they will remain beneath the administrative caps required by statute. The State Performance Penalty is included in the minimum MLR, risk corridor, and the Administrative Cap.

228.	IV P.9. Risk Corridor	146	The numerator (profit or loss) in the calculation of the risk corridor is defined, but the denominator is not. Please include a description of the revenue to be included in the denominator of this calculation.	See response to Question #33.
229.	IV P.9. Risk Corridor	146	Please provide a definition of the term "Total allowed administration calculated for the administrative cap" as used in the definition of the risk corridor: does this reflect the full allowance for administration, or the portion of that allowance used by a specific MCO?	“Total allowed administration” as used in the calculation of the risk corridor reflects the portion of allowance used by a specific MCO.
230.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	In terms of the actuarial certification, are both the MLTC Quality Performance hold-back and State performance penalties considered withholds?	In terms of the actuarial certification, only the MLTC Quality Performance hold-back is considered a withhold.
231.	IV. P 10 and 11 MLTC Quality Performance Program and State Performance Penalties	146	What percentage of the MLTC Quality Performance hold-back does Optumas assume will be earned back (as part of the actuarial certification)?	The contracted actuary has not conducted this analysis for the Heritage Health program.
232.	IV. P 10 and 11 MLTC Quality Performance Program and State	146	What percentage of the State Performance Penalty does Optumas assumed will be	The contracted actuary has not conducted this analysis for the Heritage Health program.

	Performance Penalties		earned (as part of the actuarial certification) - especially given the metrics are not yet available?	
233.	IV. P 11 State Performance Penalties	147	In this section it is stated that this program is effective beginning on the contract start date. However, performance metrics will be provided to MCOs prior to year two of the contract. Can this information be provided earlier in order to allow MCOs to manage to and report on performance relative to these metrics during the first contract year?	As Heritage Health is a new program, the State will use operational and quality reporting required in the first year of the program, including but not limited to measurements found in Attachments 7 and 14, to establish minimum performance metrics for year two of the contract that will be subject to the minimum performance metric penalty required in Neb. Rev. Stat. §71-831.
234.	IV. Q. 3. Provider Reimbursement	149	What assumptions were built into the rates to account for the requirement to pay enhanced payments in accordance with section 1202 of the Affordable Care Act?	The current managed care entities reimburse providers consistent with the requirements of section 1202 of the Affordable Care Act. The rates are built using encounter data from current managed care entities, so the enhanced payment levels commensurate with section 1202 are fully inherent in the base data.
235.	IV. Q. 8. c. Payments to Out-of-Network Providers	149	Please provide additional information regarding out of network providers that can be paid at 90% of the Medicaid rate - are there any provider types excluded from this provision?	IHS provider types are excluded from this requirement set for in the RFP.
236.	IV. Q. Provider Reimbursement	149	Are there any other special reimbursement requirements beyond what is documented	The MCO may negotiate rates with its network providers, except as otherwise provided for in the RFP.

			in this section? For example, are MCOs allowed to contract with providers at values below the Medicaid Fee Schedule?	
237.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates regarding provider reimbursement requirements and experience under managed care and/or fee for service?	The Heritage Health capitation rates are based on the reimbursement levels underlying the managed care encounter data for services currently provided via managed care and FFS reimbursement levels for services currently provided via FFS.
238.	IV. Q. Provider Reimbursement	149	Where any specific assumptions built into the initial rates to account for the requirement that MCOs enter into value-based purchasing agreements with providers?	No assumptions were built into the initial rates to account for value-based purchasing agreements.
239.	IV. Q. Provider Reimbursement	149	What assumptions were built into the rates to take into account access to care requirements?	No assumptions were built into the rates to take into account access to care requirements. The base data consists of FFS data and data from the current managed care entities. All of these organizations are able to meet access to care requirements, so the data was considered sufficient to account for access requirements.
240.	IV. Q. 10. Critical Access Hospital Contracting and Reimbursement	152	"Please clarify each of the following with regard to Critical Access Hospitals: 1) What assumptions are built into the rates? 2) What protections exist if MCOs experience utilization at these facilities different than that assumed in the rates?	Rates are built using the payments made by current managed care entities to critical access hospitals. This includes both claim payments and supplemental payments made outside of the claims system. Currently no protections exist. Currently, the State does not allow for a settlement process and this is currently under review.

			3) Will the State consider a settlement process with MCOs to ensure that there is no variation in payment between MCOs based on differing utilization of Critical Access Hospitals?"	
241.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments	152	"Please clarify each of the following with regard to the UNMC supplemental payments: a) please describe the process of developing the amount to be paid to each provider eligible for these supplemental payments b) please describe the assumptions for the development of the amount built into the rates on a quarterly basis to account for these payments"	To develop the UNMC rate the contracted actuary receives a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists are used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently unmanaged populations, and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC. The UNMC PMPM amount is provided in Attachment 11. Additionally, UNMC services are concentrated in professional service categories. Lab and Radiology, PCP, EPSDT, Specialist, and Other Practitioner represent 96% of the UNMC utilization. UNMC services are concentrated in Rating Region1; Rating Region 2 has about half as many services provided by UNMC. Statewide, UNMC utilization represents about 3.5% of Lab and Radiology services, about 0.5% of PCP and Other Practitioner utilization, and less than 0.5% of the other service categories.
242.	IV. Q. 11. University of Nebraska Medical Center (UNMC) Physician/Practitioner	152	Since the UNMC amounts built into the rates are estimates, there is the potential for the actual payout	The process outlined in the RFP is the methodology currently approved by CMS so there is not an intention to implement a reconciliation process.

	Payments		to be more or less, which puts the MCOs at risk. If this is intended to be a true pass though (i.e., every dollar received is paid out to providers or paid back to the State)?, there needs to be a reconciliation process so there are not winners and losers. Does DHHS intend to implement a reconciliation process?	
243.	IV. Q. 9. Reimbursement to FQHCs and RHCs	152	"Please provide the following for FQHCs and RHCs: a) a listing of FQHCs and RHCs and the current encounter rates by region b) What payment methodology is embedded in the base data (e.g. encounter rates vs. rates per service)? c) what adjustments were made to the base data to include these provider types in the final rates(e.g., payment methodology changes)? d) please clarify that MCOs pay FHQC and RHC providers similar to other PCPs, clinics, etc."	See Attachments 27 and 28: "FQHC-2015-Rates and "Rural Health Clinic Rates Effective 07012015" respectively. The base data prior to adjustment contains reimbursement at each FQHC's PPS rate. FQHCs receive the PPS rate for each patient encounter. These rates are traditionally been updated annually; however, effective January 2016, the State is moving to a re-based APM payment. To account for the impact the reimbursement change will have on the Heritage Health capitation rates, the contracted actuary identified all FQHC utilization in the base data and priced it at the new APM rate. The pricing was done separately for the FY14 and FY15 base data sets, and the resulting impact was blended together consistent with the overall rate development. MCOs are expected to pay FQHC and RHC providers at the designated per visit rate.
244.	IV. T. 4. Encounter	177	Will historical data be	Historical pharmacy data will be provided to MCOs upon member assignment.

	Data		provided to MCOs upon member assignment, to assist with care management and other operational requirements?	
245.	IV.Z. Claims Broker Services	192	"A description of the annual calculation of the per claim administrative fee is described in this section. Please provide: a) additional detail regarding the timing of the payment of this fee. b) an estimate or an actual value for the initial amount of this fee upon program implementation. c) Please provide an estimate of the volume of claims that would be expected to be processed by the claims broker MCO."	This information will be provided to the awarded contractor during the implementation timeframe outlined in Section IV.Z.3.
246.	V. Proposal Instructions	196	This section states that "Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order" however no additional information is provided regarding a cost proposal. Please provide any additional information regarding any cost proposal	No additional cost proposal information is required.

			information that bidders should provide.	
247.	Attachment 1	All	Please provide a breakout of the members shown in this exhibit into those that would be expected to be covered by the contract, and those who would remain covered under fee for service.	As nearly all Medicaid eligible individuals will be included in Heritage Health, the State does not currently have an exact figure by county for the number of individuals that will continue to receive core benefits and services through the fee-for-service program. This information will be posted to the procurement website as part of the second round of questions and answers.
248.	Attachment 11	All	Please break out the Non-Medical Load (NML) shown in the Optumas Pre-Bidders Conference presentation into the relevant components for each category of aid and each region.	See Response to Question #112.
249.	Attachment 11	All	Please describe the process used to arrive at the varying NML components by category of aid and region, considering both the PMPM values and the percentages.	See Attachment 21: “Non-Medical Load Assumptions”. NML is based on the experience of current Managed Care Entities.
250.	Attachment 11	All	Please confirm that the values shown in this exhibit represent the lower bound of the actuarially sound rate range.	Confirmed.
251.	Attachment 11	All	It was stated that these rates are the lower bound of the range. Has DHHS historically paid the low end of the rate range? If no, at what point in the range have the MCO	MLTC has historically paid the physical health managed care rates at the mid-point range. The behavioral health rates have been variable.

			capitation rates been set?	
252.	Attachment 11	All	Please provide the high and low end range of each assumption and adjustments used to create the high and low end rates.	The rates that have been discussed during the bidder's conference reference the lower bound, thus all assumptions that were shown in the power point reflect the lower bound assumption values. The ranges around the assumptions will not be shared.
253.	Attachment 11	All	It was stated that these rates are the lower bound of the range. When the rates are updated for retroactive eligibility and other changes, is it DHHS' intention to pay at the low end of the range?	While it has not been historical practice for MLTC to pay at the lowest end of the rate range, a final decision will be made in the context of the Department's budget.
254.	Attachment 11	All	"Are the rates shown in this exhibit net or gross of each of the following: a) MLTC hold-back (1.5%) b) State Performance Penalties (0.25%)"	The rates shown in the "Medical PMPM" columns of Attachment 11 are gross MLTC hold-back (1.5%) and net State Performance Penalties (0.25%). The rates shown in the "Developed Rate" and "Total Rate" columns of Attachment 11 are gross MLTC hold-back (1.5%) and gross State Performance Penalties (0.25%). The State Performance Penalties is considered a component of non-medical load and is added in along with other administrative funding.
255.	Attachment 13	All	Based on the wording of this Statute, it appears that these requirements apply to "at-risk managed care service delivery for behavioral health services." Please confirm that this statue applies to the anticipated contract, which covers service delivery for behavioral health and physical health services.	Confirmed.

256.	Attachment 13	All	Each of sections IV.P.10, 11, 12, 14, and attachment 15 which is referenced by section IV.P.13 make a reference to this attachment, but section IV.P.9 does not. Please confirm that section IV.P.9 was written in accordance with paragraph (2) of this attachment, and that this is the only section of the scope of work written to conform to the requirements in this paragraph.	Section IV.P.9 is written in accordance with paragraph two (2) of Attachment 15.
257.	Attachment 13, 15 and IV.P.9 - 14	All	"The concept of revenue for the MCO and related parties is addressed multiple times in multiple calculations. The language is similar but not always consistent in each of these sections. Please define what is meant by this language, providing any instances in which the definition would be different between calculations. For example, the definition of Risk Corridor Calculation on page xvi states that the calculation ignores any forfeited hold-back, and the definition of Qualifying	See response to Question #33.

			Revenue (for the risk corridor calculation) per page xv states that any earned hold-back is not factored into the calculation. If a MCO had $150 of holdback and it was determined the MCO earned $100 of the holdback through the QPP, how much of the $150 holdback is included in the calculation/definition of Qualifying Revenue for the risk corridor? "	
258.	Attachment 15	All	"Please define the term ""Risk Bearing Partners."" In particular, a) please clarify whether providers with whom an MCO has a value-based contract as described in section IV.Q.6 (p. 150) would be included in this definition b) please clarify whether providers with whom an MCO has a contract including an physician incentive plan as described in section IV.Q.6 (p. 150) would be included in this definition"	Providers with whom an MCO has a value-based contract or providers with whom an MCO has a contract including a physician incentive plan as described in Section IV.Q.6 would be included in this definition.
259.	Attachments 10-11	All	Please provide a detailed development of the copayment assumption built into the rates, including the	Allowed copayment amounts are specified at 471 NAC 3-008. Copayments are collected at the discretion of the MCO, but the capitation rates are developed in accordance with 42 CFR 447.56(d). This adjustment is a 0.02% reduction in the total PMPM in each Rating Region.

			actual amounts collected historically by MCOs and by the state under fee for service during the base period, and any adjustments made to arrive at the expected amounts to be collected by MCOs under the contract	
260.	Attachments 10-11	All	At the bidders' conference, it was stated that only FY2015 experience was used to develop the Foster Care rates because PRTF experience in FY2014 was much higher than FY2015. Please explain the reason for the decrease. Was there a policy change?	The current managed care entity described the variance in utilization for PRTF as a decrease in requests for PRTF. It was assumed that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns.
261.	Attachments 10-11	All	"Regarding the base data: a) Please discuss any issues or concerns related to data collection. b) Does the data book capture all expenses that will be the MCOs' responsibility, even those paid outside of the claims system? c) Please confirm that encounter data represents actual reimbursements by MCOs and were not repriced to 100% of a fee schedule? d) Please provide average	There are no concerns about data collection. Data sources are comprised of FFS data and MCO encounters. Current MCOs are involved in validating the encounter data. The results of this validation confirm that encounter data is not underreported. All payments are captured. Supplemental payments such as CAH settlements and PCP shared risk agreements are added in to the base data. Encounter data represents actual reimbursements by MCOs were not re-priced to 100% of a fee schedule. The level of detail requested in part d of the question is not available.

			payment rates (reflected in the data book) relative to the fee schedule by region, category of aid, and category of service."	
262.	Attachments 10-11	All	"Can the databook be further split by: a) to separate populations and services under managed care versus fee for service during the base period? b) separate out all base data and assumptions for pharmacy by generic, specialty and brand c) by hospital type (e.g., critical access hospital, out-of-state, etc.)? d) drug utilization and unit cost for HEP-C treatments, e) ASD-related benefits."	No populations were under FFS for their Behavioral Health services. Physical Health services were provided under FFS for the following populations: AABD 21+ M&F-WWC; LTSS (Institutional) – Dual; LTSS (Institutional) - Non-Dual; LTSS (Home and Community Based) – Dual; LTSS (Home and Community Based) - Non-Dual; Dual. Pharmacy services were provided via FFS for all populations. This level of detail is contained in the base data books that are attachments to the RFP. This level of detail is not available for part b of the question. The impact of ASD related benefits is itemized in the Pre-Proposal presentation provided by the contracted actuary. Please submit further detail for c and d during the second round of questions.
263.	Attachments 10-11	All	Please provide the IBNP assumptions by region, category of aid, category of service and data type (FFS versus managed care).	See the Attachment 25: "IBNR Assumptions by Source". IBNR factors are shown on a statewide basis because payment patterns do not materially differ between rating regions.
264.	Attachments 10-11	All	Please provide a detailed development of the dispensing fee assumption built into the rates, including	Non-independent pharmacies were assumed to have a $2.50 dispensing fee and independent pharmacies were assumed to have a $4.45 dispensing fee. The independent pharmacy dispensing fee is the State FFS dispensing fee set for independent pharmacies. The $2.50 non-independent pharmacy dispensing fee

			the dispensing fee amounts reflected (classified into independents and non-independents as appropriate) in the base period, and any adjustments made to arrive at the dispensing fee amounts expected under the contract.	is based on discussions with the state and research of other states.
265.	Attachments 10-11	All	"Please provide a narrative describing how the underlying cost data and delivery counts are collected and adjusted in the development of the supplemental delivery payment and the capitation rate for all related categories of aid in order to account for each of the following: 1) limitations on payment (i.e. due to stillbirth or missing inpatient claims) 2) adjustments for maternity time periods that do not fall completely within the base period extended, to ensure that all costs associated with the deliveries shown on that exhibit were included, regardless of when the care was delivered. For example, please confirm that a delivery that occurred a month after the beginning of the experience period or a month	A qualifying delivery procedure code must be found on an encounter in order for the maternity experience to be captured in the rates. Currently the State does not pay a supplemental payment for stillbirths, so those expenses are not in the supplemental payment and remain in the regular monthly capitation rate. When a qualifying delivery event is found in the data, the contracted actuary captures all other expenses for that member in the five months prior to delivery date and the two months post-delivery. All of these expenses are re-categorized from the member's original aid category to the Maternity aid category. The maternity cell separately captures maternity-related services for all populations, dating back 5 months from the date of delivery (5 months prenatal) and going forward 2 months after the delivery (2 months post-partum). Prenatal costs for delivery occurring within the first five months of the base data period, and postpartum costs for deliveries occurring within two months of the end of the base data period could be understated in the base data. As a result, an adjustment has been made to reflect the missing prenatal and postpartum services for deliveries occurring on the left and right tails of the base data. The contracted actuary reviewed the average per-member-per-delivery costs for delivery events occurring between December 2013 and April 2015 (step one) and compared these costs with the per-member-per-delivery costs for deliveries occurring July-November 2013 and May-June 2012 (step two). The differential between the deliveries identified in step one and step two was used to adjust costs observed in step two. The overall impact of this is an upward adjustment to the

			before the end of the experience period would have been removed from both the counts and the claims. Additionally, please provide a breakout of the base data for the maternity supplemental payment using categories of service that reflect the specifics of this payment. In particular, it would be helpful to have the costs split into physician, facility, prenatal, postpartum, and delivery costs, for example."	Maternity cell of 1.8%. Maternity experience split by service type can be found in Attachment 10-A and Attachment 10-B by viewing the Maternity aid category. Please note that for this aid category member months are actually deliveries, as the denominator for the supplemental payment is a delivery event, not a covered month. Physician, facility, prenatal, postpartum, and delivery costs can not be independently itemized.
266.	Attachments 10-11	All	Please confirm that the values shown in the MM's column of the maternity exhibit are actually meant to represent deliveries	Confirmed.
267.	Attachments 10-11	All	Please describe how third party liability/ coordination of benefits are reflected in the data and rates.	Capitation rates are net of any third party payments or member share of cost.
268.	Attachments 10-11	All	Please describe the eligibility conditions for the Katie Beckett 00-18 M&F rate cell.	Medicaid eligibility for children whose parental income in disregarded due to the determination that the child meets hospital level of care. This includes families with a child or children under 18 years old who have one or more of the following: • A ventilator to breathe • A tracheostomy • Need for complex nursing services to be provided at home • Use excessive amounts of medical supplies, equipment,

				and/or therapies
269.	Attachments 10-11	All	All of the values are identical in each of 10-A and 10-B for the Katie Beckett 00-18 M&F Rate cell. Please confirm that this is a statewide rate cell and the counts represent a statewide count.	Confirmed.
270.	Attachments 10-11	All	"Summary detail was provided during the Pre-Proposal conference regarding at least 7 policy changes. However, these changes were grouped into 5 impacts, for which only summary information was shown. Please provide each of the following, with detail down to the level of region, fee for service versus managed care, category of service, unit cost and utilization impact, fiscal year, and any other breakout necessary to understand the change: a) a narrative describing each of the policy changes, including the effective date and the development of the impact of each item, describing each of the data, assumptions and methods used to calculate the impact.	Please see Attachment 22: "Heritage Health Rate Development Narrative". This question appears to be applicable to the Immediate Enrollment adjustment and the Behavioral Health copay adjustment. Immediate enrollment was effective February 2014, so they are inherent in 17 months of the base data and absent from seven months. Beginning January 2014, the State implemented a $2.00 copay for certain Behavioral Health services. The January 2014-June 2015 base data already reflected the copay implementation, so only the September-December 2013 Behavioral Health encounters were adjusted to reflect the copay policy change. The only adjustments included to get the data on a comparable basis as show in the attachments were IBNR, Subcapitation Payments, and Supplemental Payments. IBNR is detailed in Attachment 25: “IBNR Assumptions by Source”. Across both FY14 and FY15 Supplemental Payments are worth $11.2 million on a statewide basis and Subcapitation Expenses are worth $13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represents non-claims payments, such as CAH settlements. The value of all adjustments applied to get from Attachments 10-A--10-D is in the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas).” Additionally, see Attachment 20: “COA-level Rate Development”, to see the application of rate adjustment values.

			b) the impact of the policy change further broken out (beyond the breakouts listed above) into 1) how much of the impact of the policy change is already reflected in the base data 2) how much of the impact of the policy change was included as an adjustment to the base data in order to get all of the base data on a comparable basis, as shown in attachments 10-A - 10-D 3) how much of the impact of the policy change was included as an adjustment after the summary of the base data shown in attachments 10-A - 10-D was complete, and before final rates were developed as shown in attachment 11"	
271.	Attachments 10-11	All	"The trends used to develop these rates were shown in the Pre-Proposal Conference Rate Presentation by COA and separately by COS. a) Please confirm that the trend rates shown are per year trends, and, if so, please	Trend rates shown are annual trend rates. Trends are developed and applied by category of service and category of aid. This allows for each detailed trend rate to be compounded for the necessary amount of time depending on the data source. "COS and COA Trends" contains the trends by category of service and major category of aid.

			describe the process of calculating a single trend rate for a category of aid for which different components of the total PMPM are trended for different time periods. b) Please provide these assumptions at the level of detail used in the rate development (i.e., break these trends out by both of these dimensions at one time)."	
272.	Attachments 10-11	All	Please clarify any adjustments made to the pharmacy costs shown in the data book and rates. Specifically, have the expenses been reduced for both federal and supplemental rebates?	The pharmacy amounts in the data book and rates have not been reduced for rebates.
273.	Attachments 10-11	All	Please provide the values of the pharmacy rebates separated by federal and supplemental and by fiscal year, region, and rate cell.	Pharmacy rebates are not included in the capitation rate development. Therefore, this level of detail is not available.
274.	Attachments 10-11	All	Please confirm that there is no premium or provider taxes.	The contracted actuary did not build in premium or provider taxes into the capitation rates.
275.	Attachments 10-11	All	Please provide membership projections by rate cell for CY17 and any later time periods available.	This level of detail is not available.

276.	Attachments 10-11	All	Please provide the definition of units for each category of service shown in the data book.	See Attachment 29: "Unit Definitions for Category of Service".
277.	Attachments 10-11	All	Please clarify whether or not GME expenditures are reflected in the base data or rates. If so, please provide these values separately.	GME expenditures are not included in the base data or the rates.
278.	RFP Section IV.Z	191	Regarding the Procurement of FFS Claims Management and Processing services, can the State share how it will evaluate which MCO will be awarded this business and what the award criteria will be?	See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html
279.	RFP Section IV.S.10	169	Does the State have documentation that it could make available to bidders on the Encounter Submission process? For example: should we assume that the HIPAA 837 I&P Companion Guides on the Nebraska Medicaid website are not only for Provider submissions for FFS Medicaid - but are also for MCO's to submit encounter data? In addition, does the State have any information it could share on the format of ancillary	The 837 I&P Companion Guides on the Nebraska Medicaid website are for both- Provider submissions of claims and for MCO submissions of encounters. The MCO receives the 999 File Acknowledgement, and 277 Claims Acknowledgement Transactions. A Month-To-Date Summary Report is also sent to the MCOs.

			encounter submission file formats (e.g. error files returned from the State, acknowledgement files, provider file submissions)?	
280.	Attachment 7	1	There is an asterisk on page 1 of Attachment 7 next to Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 1 of Attachment 7.
281.	Attachment 7	2	There is an asterisk on page 2 of Attachment 7 next to Child and Adolescent Major Depressive Disorder, Suicide Risk Assessment (SRA); however there is no explanation of the asterisk. Can the state provide clarification?	The State is hereby amending to remove the astrick on page 2 of Attachment 7.
282.	Attachment 14	n/a	Is the calculation for Claims Processing Timeliness and Pharmacy Claims Processing Timeliness business days or calendar days?	See section IV.S.3.
283.	Summary of bidder's corporate experience	197	The RFP language states that the State will use no more than 3 narrative project descriptions submitted by the bidder during its evaluation of	See the response to Question #44.

			the proposal. For entities that have more than 3 project descriptions to provide, would the State prefer that bidders provide only 3 or all applicable experience?	
284.	Attachment 19	17	Question 97, regarding value-based purchasing, asks bidders to provide evidence of effective use in Nebraska or other markets. Medicaid membership tends to be more medically-complex than Commercial membership. To allow for a more accurate comparison, for evaluation purposes, would the State consider that evidence be limited to only Medicaid experience? Alternatively, would the State consider weighing Medicaid experience differently than commercial?	A bidder should include in its response to Question # 97 a description of the MCO's approach to implementing a value-based purchasing model with Medicaid membership. In its presentation of evidence of effective use in Nebraska or other markets, a bidder should identify whether the applicable membership was Medicaid or commercial.
285.	RFP Section F. Member Services and Education, part 4, Item d	70	The SOW says “The MCO must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the MCO’s website, the materials that the members can find on the website and how to obtain	See response to Question #144.

			written materials if the member does not have access to the website." On page 80, Item b.1 it says "The MCO must send a welcome packet to new members within ten business days of receiving the new member file." Please clarify the difference between new member materials and the welcome packet?	
286.	II. Procurement Procedures, H.	4	Does the State want extra copies in addition to the one (1) original?	No, the State is only requesting one (1) original of the entire proposal response.
287.	II. Procurement Procedures, H.	4	Is there a specification for font size and style?	See response to Question #56.
288.	II. Procurement Procedures, H.	4	What are the margin and spacing requirements for the final proposal?	There are no such requirements.
289.	II. Procurement Procedures, O.	6	The RFP indicates only top scoring bidders may receive reference checks. Will the bidder be required to supply reference contact information? If so, where should bidder include this information within RFP the response?	The Bidder may provide references within the proposal response. References may be in a separate identified tab within the proposal response.
290.	III. Terms and Conditions, F. 3. a & c	10	Section a. states MCOs must file all contracts of reinsurance or a summary of the plan of self-insurance,	If the MCO chooses to self-insure, the maintenance of reinsurance agreements will not apply.

			however section c. states the MCO must maintain reinsurance agreements throughout the contract period including any extension(s) or renewal(s). If the MCO chooses to self-insure, how do the requirements of 3. c. apply to a self-insured MCO?	
291.	IV. Project Description and Scope of Work, D. 3. j.	51	With respect to "additional staffing requirements," are all prior authorization, concurrent review, and member services staff required to physically work in Nebraska? Which specific care management staff are required to work in Nebraska?	Per Section IV.D.3.j. all additional required staff in Section IV.D.3 must be located in the State with the exception of claims and encounter processing staff and certain care management staff.
292.	F. Member Services and Education, 11.	77-79	Is there currently a Nebraska requirement for all providers to utilize a consistent electronic medical records (EMR) program to aid MCOs in easily obtaining records?	There is no requirement for providers to utilize a consistent electronic medical record program. A provider may select a vendor, if the provider opts to install an electronic medical record in their practice.
293.	F. Member Services and Education, 13. c. iii.	81	What defines an "attempt to contact the member"? Do mailings count in this requirement for 3 attempts?	Attempts may include written correspondence sent via the US Postal Service or documented telephone calls.
294.	F. Member Services and Education, 13. c. iii.	81	The second part of iii. states that if the member has lost or never received a welcome	This is acceptable.

			packet that the MCO must resend it. If the welcome packet was returned to the MCO due to an invalid address and the member is unable to reach, is it acceptable not to resend the packet to the invalid address as long as the member is added to the monthly unable to reach report sent to MLTC?	
295.	M. Quality Management, 1. c.	118	How is "sufficient number of qualified personnel" defined? Is there an expected ratio?	The Bidder should propose the number of qualified personnel to comply with all QM requirements in a timely manner.
296.	M. Quality Management, 4. a.	120	How many child (adult guardians) and adult Medicaid members are required to be in attendance at QAPIC meetings? Is it a specific ratio or percentage of total membership?	The Bidder should propose the number of family members/guardians of children or youth who are Medicaid members and adult Medicaid members to participate in the QAPIC.
297.	IV. Project Description and Scope of Work, P. 5.	144	Is there a separate billing process for Supplemental Delivery payments or is submission of the encounter data evidence of the delivery to generate payment?	See response to Question #99.
298.	IV. Project Description and Scope of Work, P. 7. b. iii	145	Please clarify the reimbursement of the HIPF to the MCO and timing of payments. Will the MCO receive a lump sum	An estimate of HIPF liability will be built prospectively into the capitation rate. After the final tax bill is paid the following year the State will calculate a settlement payment based on the difference between what was paid during CY2017 in the capitation rates and the actual HIPF amount.

			adjustment for reimbursement of HIPF payment?	
299.	IV. Project Description and Scope of Work, P.12. c.	148	If the MCO contracts with a TPA for administrative services at a percentage of revenue, what documentation is the MCO required to provide under section c.?	The MCO must provide documentation to enable the State to support any expenses provided on the quarterly financial report.
300.	IV. Project Description and Scope of Work, Q. 6. b.	150	Please provide details on how the percentage of the value based purchasing agreements will be calculated. Will all provider types be included in this calculation (i.e. practitioner, ancillary, hospital)?	See response to Question #103.
301.	Attachment 6: Reporting Requirements	9-10	The reporting requirements for the Audited Financial Statement and the Department of Insurance Financial Report is 30 calendar days following the 12th month of the contract year • The quarterly filings are not due until 45 calendar days following the end of a quarter • The filing checklist on the Nebraska Department of Insurance website	The deadline for the Audited Financial Statement is 30 calendar days following the 12th month of the contract year. The due date for the Department of Insurance Financial Report in Attachment 6 is hereby amended to read as follows: "June 1".

			shows due dates of 6/1 for audited financial statements, and 3 /1 for annual statement	
302.	Attachment 19: Proposal Statements and Questions, Question 106.	19	"Prioritized business functions for resumption of operations and responsible key personnel" We generally do not share the specific priority of functions nor key personnel at a named person level, rather, we speak to the process for prioritizing functions and reviewing key personnel lists. Would this be acceptable or does it need to be more specific?	This would be acceptable.
303.	Evaluation Criteria	N/A	Can the department please provide a more comprehensive scoring breakdown, specifically relating to scoring for staffing (i.e., will the MCO be evaluated on how many positions are filled at time of RFP submission, or will MCO be evaluated on proposed staffing plan meeting the RFP requirements?	In order to protect the integrity of the evaluation process, the factors that will be scored within the evaluation criteria will not be provided. See the Evaluation Criteria by clicking on the link below: http://das.nebraska.gov/materiel/purchasing/5151/5151.html
304.	RFP, Section IV.B.1.	RFP page 33	Could MLTC provide the file layout/format or data	The 834 transaction is sent to the MCOs to provide eligibility data along with proprietary supplemental and unborn files. Please see Attachment 30: "Supplemental Enrollment File" and

			dictionary of the Eligibility Data being supplied?	Attachment 31: "Unborn File".
305.	RFP, Section IV.I.17.vi.	RFP page 103 and RFP Attachment 5, page 7	Could MLTC elaborate on the specific provisional credentialing requirements for behavioral health providers?	Regulations applicable to licensure of mental health practitioners are available at 172 NAC 94. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf
306.	RFP Attachment 2, Access Standards, Geographic Access Standards, #4	RFP Attachment 2, page 2	Could MLTC clarify how the access standard will be measured? For example, will it be measured by the number of miles from the member's personal residence (no greater than X miles) or by the number of hours of travel time by car (no greater than X number of hours)?	Access standards are measured by the number of miles from the member's personal residence as set forth in Attachment 2.
307.	RFP Attachment 4	RFP Attachment 4	At what frequency will MCOs assess medical home providers for continued participation?	See Section IV.I.7.e.
308.	RFP Attachment 19, #45	RFP Attachment 19, page 8	Will MCOs be permitted to query the enrollment data to confirm the provider identification number in order to ensure that providers are enrolled in Medicaid and have a valid identification number?	MMIS will provide the MCOs a file (interface) with current provider information.
309.			It has come to my attention that the most recent Medicaid contractual information is not up to date with the law in	See response to Question #2.

			Nebraska. The antiquated language “”Primary care provider (PCP) A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (Dos) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology” would prohibit me from continuing to provide care for Medicaid patients in Nebraska as I no longer have a collaborating or supervising physician. This verbiage needs to change immediately to reflect the changed law in Nebraska.	

310.	Glossary of Terms	RFP page xv	"We request two points of clarification relating to the definitions of “Qualifying revenue (for the risk corridor calculation)” and “Qualifying revenue (for the administrative cap calculation)”. (1) Both definitions indicate that qualifying revenue is “[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under this contract.” Please confirm that no amounts would be double-counted as revenue based on these definitions. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once. (2) Both definitions indicate that qualifying revenue ignores “federal and state	Points one and two are confirmed.

			premium taxes and non-operating income." Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145)."	
311.	Glossary of Terms	RFP page xvi	Please confirm that in the definition of "Risk corridor calculation", the reference to "a contract" should be "this contract". Could the RFP be revised to reflect this?	The definition of "Risk corridor calculation" is hereby amended to read as follows: **Risk corridor calculation:** The computation of a MCO's profit or loss by MLTC's actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under this contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.
312.	Glossary of Terms	RFP page xvii	"We have two clarification requests related to the definition of "Subcontractor": (1) Please confirm that the reference in the first sentence of the definition to "a contract" should be "this contract". (2) Please confirm that a provider (such as a hospital) that credentials its own staff would not be considered a subcontractor based on such credentialing activities.	1.) See response to Question #311. 2.) Confirmed.

			Could the RFP be revised to reflect these clarifications?"	
313.	Glossary of Terms	RFP pages ix and xvi	"We are concerned that the definitions of “administrative expense rate” and “related-party administrative expense” could be interpreted to mean that actual administrative costs incurred by the MCO and paid to a related party would not be included in the calculation of the MCO’s administrative expense. Could the State revise the RFP clarify that administrative expenses actually incurred will be counted toward administrative expense even when paid to a related party? For example, these definitions could be revised: “Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that were incurred in the contract year. In the event the MCO paid any amounts for administrative services to a related party, only those administrative costs actually incurred by the related party	The State is reviewing this question further. This information will be posted to the procurement website as part of the second round of questions and answers.

			in connection with the administration of this contract will be included in such costs." "Related-party administrative expense: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization such as flat monthly administration fees. Such fees are not considered in the calculation of administrative expense under this contract. Related-party administrative expense does not include amounts paid to a related party for administrative costs actually incurred by the related party in connection with the administration of this contract." "	
314.	Glossary of Terms	xvii	The definition of specialty drug is somewhat restrictive. Can the MCO use its own list of specialty drugs to be dispensed through specialty pharmacies or can ONLY drugs that meet this definition be dispensed through specialty pharmacies?	See response to Question #75.
315.	RFP § II(H)	4	Are there any font or font size requirements applicable to	See the response to Question #56.

			the proposal responses?	
316.	RFP § III(F)(4)	10	"The RFP requires that the MCO maintain Errors and Omissions ("E&O") coverage at $10,000,000 per occurrence and Cyber Liability coverage at $10,000,000 each occurrence. Neither Managed Care E&O coverage nor Cyber Liability coverage is commercially available on an occurrence basis. In connection with another recent RFP, we surveyed 15 insurance carriers and E&O policies are only written on a claims-made basis. The markets stated it could not be changed. Please confirm the State will accept claims made policies for E&O coverage and Cyber Liability coverage. If necessary the MCO could agree to purchase tail coverage if the coverage is moved to a new carrier."	Yes, the State will accept the Cyber and E&O coverages on a claims made basis. The E&O coverage and Cyber Liability coverage is not commercially available on an occurrence basis therefore the claims made basis is acceptable.
317.	RFP § III(GG)	20	This section provides that "State will render payment to Contractor when the terms and conditions of the contract	Capitation rates will be paid prospectively.

			and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State." Medicaid MCOs are typically paid for services in advance of (or at the beginning of) the month for which the payment is made. Advance payment also seems to be contemplated by RFP § IV(P) generally. Please confirm that MCOs will be paid prospectively.	
318.	RFP § III(II)	21	Please confirm that the provisions of RFP § IV(P)(7), which relate to the reimbursement by the State of the Health Insurance Providers Fee, take precedence over the language of this section.	Confirmed.
319.	RFP § III(NN)	23	Could the State provide more details regarding the submission process related to proprietary information? The instructions state that 1 original proposal should be submitted and proprietary information should be included in a separate package. Does that mean that the original should be a redacted version with the	Either way is acceptable as long as the proprietary information is labeled and in a separate sealed envelope.

			proprietary information removed (and the redacted information provided in a separate envelope)? Or would the State rather receive one complete copy of the proposal and one redacted copy suitable for public posting?	
320.	RFP § IV(A)(1)	30-31	RFP numbering in this section jumps from 1 to 9….was anything omitted as a result?	The jump from IV.A.1 to IV.A.9 was inadvertent. No information was omitted.
321.	RFP § IV(B)(1)(c)	33	The RFP states that Medicaid and CHIP eligibility will be conducted annually. Continuous eligibility in CHIP is limited to six months by statute. Will the annual review amount to continuous eligibility or will reviews continue on a rolling basis if and when DHHS is alerted to a change in family circumstances that could affect eligibility?	Review will be annual unless MLTC is alerted of a change that may affect eligibility.
322.	RFP § IV(B)(3)(f)(iii)	34	This provision provides than an MCO will be removed from the auto assignment algorithm if it has 40% or more of statewide enrollment. In the event the State only awards two contracts, what threshold would be used?	In the event only two contracts are awarded, this provision will be revised to reflect 65% or more statewide enrollment.

323.	RFP § IV(C)(10)(a) and (b)	41-42	Will the State require the MCO to open an Insolvency Bank Account? If yes, how much is the minimum Insolvency amount required by the State? When is it required to be opened and funded?	This will not be required.
324.	RFP § IV(C)(10)(a) and (b)	41-42	Aside from the Insolvency Bank account (if any is required), will the State also require the MCO to open a separate Statutory Deposit Bank Account? If yes, how much is the required statutory deposit amount? When is it required to be opened and funded?	This will not be required.
325.	RFP § IV(C)(14)and RFP § IV(K)(2)	43 and 110	The first section referenced specifies "The MCO must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 120 calendar days prior to their planned implementation." whereas the 2nd section referenced specifies "2. The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a	The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation.

			minimum of 90 calendar days prior to their planned implementation." Can MLTC confirm if the submission must be made at least 90 or 120 days?	
326.	RFP § IV(D)(3)(j)	51	Please clarify the requirement that "[a]ll additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff." We have found that having a mix of in-State and out-of-State personnel is the best way to serve members. For example, we plan to have member services and provider services personnel based in Nebraska to provide in-person services to members and providers. However, we also maintain member and provider call centers elsewhere that also would be available to assist Nebraska members and providers. Likewise, we would have in-State at least one Nebraska-licensed registered nurse or physician's assistant on our prior authorization staff, as	See response to Question #291.

			required, and we would support the prior authorization function through centralized services elsewhere. Please confirm this type of structure is consistent with this requirement.	
327.	RFP § IV(E)(1)(d)	52	"We note that the requirement that services be rendered by providers enrolled as MLTC providers does not apply to emergency services pursuant to § IV(Q)(15) on page 153. Please confirm that this requirement would also not apply to the following services: • Urgent care services performed out of state; • Specialty services unavailable within the MCO's network (for example, a member is referred to a specialty center out of state); and • Value-added services."	Confirmed.
328.	RFP Glossary of terms and § IV(E)(11)(b) - (d)	58-60	Please provide additional clarification regarding the difference between the Contractor's formulary and the preferred drug list ("PDL"). We understand that	See response to Question #75.

			MCOs are required to follow Nebraska's PDL. However, the RFP contemplates a separate MCO formulary (see, in particular, § IV(E)(11)(b)(iv)(a)) which must be approved by MLTC. Does this mean that the MCO can cover more drugs than are on the Nebraska PDL? What types of differences between MCO formularies and the Nebraska PDL does MLTC anticipate?	
329.	RFP § IV(E)(11)(b)(ix)	59	This section states that MCOs are permitted to require prior authorizations under certain circumstances so long as the prescriber and the pharmacy are notified within 1 business day of approval or denial. Please confirm that MCOs are not required to contact the pharmacy with respect to retrospective DUR determinations.	The MCO is not required to contact the pharmacy if an auto-drug look back was performed and payment was denied due to lack of drug-utilization history.
330.	RFP §§ IV(H)(3)(a)(ii) and IV(N)(4)(b)	88 and 127	Section IV(H)(3)(a)(ii) states that "any decision to deny a service authorization request . . . must be made by a health professional who has appropriate clinical expertise in treating the member's	Regardless of reasoning for service authorization denials and limitations, all decisions must be made by a health professional who has appropriate clinical expertise in treating the member's condition or disease.

			condition or disease." Section IV(N)(4)(b) contains similar language. Please confirm that this requirement does not prevent non-clinical MCO personnel from issuing denials and limitations based on administrative criteria not related to medical necessity (for example, request is for an excluded product, request is outside terms of coverage, etc.)	
331.	RFP § IV(I)(4)(e)	96	"Please confirm the following with respect to the requirement that MCO's network include providers currently serving Medicaid members: • The requirement applies only to the MCO's initial network as of the contract start date; • MCO is not required to contract with any provider that does not pass credentialing; and • MCO is not required to contract with any provider that refuses to accept MCO's standard provider agreement applicable to such provider's type and/or specialty."	IV.I.4.e applies only to the MCO's initial network as of the contract start date. A MCO is not required to contract with providers who do not meet credentialing standards that have been approved by MLTC per Section IV.I.14. A MCO is not required to contract with any provider that refuses to accept the MCO's applicable provider agreement; however, all provider agreements must be in accordance with requirements in the RFP.

332.	RFP § IV(I)(4)(j)	96	When does MLTC anticipate making available to MCOs the list of Medicaid eligible providers?	A list of Medicaid-eligible providers will be posted on the procurement website as soon as it is available. This information will be posted to the procurement website as part of the second round of questions and answers.
333.	RFP § IV(I)(8)(e)	99	"This section provides that "[t]he MCO must not incorporate branding of any pharmacy onto member ID cards. However, § IV(F)(9)(h) expressly requires MCO to include on the ID card "[t]he name or identifying trademark of the MCO and the prescription benefit manager." However, in some cases an MCo's PBM might be affiliated with a national pharmacy chain. Given the potential conflict above, please confirm that: • An MCO may elect to include the PBM routing information (BIN/PCN/RxGroup) without including the PBM logo on the card; and/or • The prohibition in § IV(I)(8)(e) will not prohibit MCO from including its PBM	Retail pharmacy branding may not appear on a member ID card. The MCO's contracted PBM branding may appear on a member ID card, but not if it reflects affiliation with a retail pharmacy chain.

			information on the member ID card as contemplated by § IV(F)(9)(h) even if that logo includes pharmacy branding."	
334.	RFP § IV(L)(6)(h)	116	This provision requires that the MCO develop engagement tools to improve engagement with pregnant members and help identify high-risk pregnancies. This type of activity seems to be member education, not member marketing. See, e.g., the definition of "Marketing" in the Glossary of Terms and RFP § IV(G)(1)(b), which states that "[m]arketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving his/her health status." Why would the activities contemplated in § IV(L)(6)(h) be included in the Marketing Plan? Shouldn't the MCO's plans for pregnant member engagement contemplated in § IV(L)(6)(h) be submitted separate from the Marketing Plan?	Bidders should not address IV.L.6.h in the Marketing Plan. Bidders should address IV.L.6.h in Attachment 19 - Question #35.
335.	RFP § IV(L)(6)(i)	117	Should this provision be	IV.L.6.i is hereby amended to IV.L.6.h.iii.

			numbered § IV(L)(6)(h)(iii)? If not, please clarify this requirement.	
336.	RFP § IV(O)(1)(j)	133	Please confirm that the minimum number of investigators is 1 per 100,000 members or less (as stated in § IV(D)(3)(i)) rather than 1 per 50,000 members or less as stated in this section.	See response to Question #95.
337.	RFP § IV(P)(7)	145	"Please clarify the timing on the HIPF payments in 7.b.iii. using the 2018 HIPF payment as an example. Is either of the following examples correct? Example 1 • An estimated HIPF amount will be included in the capitation rates paid during CY2017. • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • After the MCOs receive their final invoices in September 2018, MLTC will calculate a settlement payment for the difference between what was paid in CY2017 as an estimate and the final HIPF	See response to Question #298.

			amount plus gross up amount for taxes. - OR - Example 2 • MCOs will pay the 2018 HIPF based on 2017 revenue in September 2018. • The State will recalculate the capitation rates payable to the MCO for the balance of CY2018 to include an estimated amount to reimburse the MCO for the 2018 HIPF fee plus an amount for the tax gross-up • After December 31, 2018, MLTC will calculate a settlement payment for the difference between the additional HIPF-related amount paid in capitation rates for the last few months of 2018 and the actual HIPF amount plus gross up amount for taxes."	
338.	RFP § IV(P)(10)	146	Why is the 1.5% MLTC Quality Performance Program amount not explicitly built into the premium capitation rates?	The 1.5% MLTC Quality Performance Program is considered a withhold and is not additional money added to the administrative load component of the rate development.

339.	RFP § IV(P)(10)	146	This section references Attachment 13 - Neb. Rev. Stat. 71-831. Neb. Rev. Stat. 71-831 reads that the requirements outlined in Attachment 13 apply to "at-risk managed care service delivery for behavioral health services". Does this mean that the 1.5% applies only to the behavioral health portion of the premium capitation rate?	The 1.5% MLTC Quality Performance Program applies to the aggregate premium capitation rate.
340.	RFP § IV(P)(10) and (11)	146 and 147	Please explain the interaction between the MLTC Quality Performance Program and the State Performance Penalties. Is the State Performance Penalties a subset of the MLTC Quality Performance Program?	State performance penalties are not a subset of the MLTC Quality Performance Program. Quality Performance Program measures (applicable to the Quality Performance Program) are identified separately from minimum performance metrics (applicable to the State performance penalties).
341.	RFP § IV(P)(10) and (11)	146 and 147	Are the MLTC Quality Performance Program and the State Performance Penalties amounts of 1.5% and 0.25% respectively excluded from revenue in the calculation of the 3% profit risk corridor?	See response to Question #33.
342.	RFP § IV(P)(11)(d)	147	Please confirm that the modifications contemplated by this provision would only occur prior to the year in	Confirmed.

			which the performance metrics would be effective and that no modifications would be made during any year in which the modified metrics would be effective.	
343.	RFP § IV(Q)(3)	149	The enhanced payment under § 1202 of the Affordable Care Act applied to provider payments in 2013 and 2014. Would the State consider deleting this provision to avoid confusion?	The State has elected to continue enhanced payments for primary care services beyond the federal mandate.
344.	RFP § IV(Q)(6)	150	For the purpose of calculating the percentage of providers on a value-based purchasing contract, how does MLTC define provider? Will there be any effort to weight the VBP requirement by membership to ensure that a large enough percentage of members are being seen by providers in a VBP contract?	Provider is defined in the glossary of the RFP. The VBP requirement does not consider weighting by membership.
345.	RFP § IV(Q)(10)	152	Can MCOs and CAHs agree to other settlement terms, such as building any settlement due to or from a CAH into rates going forward?	Any alternative arrangement agreed upon by the MCO and CAH must be in compliance with 471 NAC 10-010.03F.
346.	RFP § IV(Q)(11)	152	With regard to the UNMC supplemental payments, please clarify the final	Amounts built into the capitation rates will not change every quarter as a result of the UNMC supplemental payment.

			sentence: "These payments are calculated into the capitation rate on a quarterly basis." Does this mean the amounts built into the capitation rates will change every quarter?	
347.	RFP § IV(Q)(11)	152	How will MCOs be required to pay the UNMC provider pass-through? Will the MCOs pay each month the per rate cell pass-through amount in the rate multiplied by the members in each rate cell?	471 NAC 18-006.02, Supplemental Payment, describes how supplemental payment amounts are determined. The MCO will make supplemental payments to UNMC related to this contract provision on a quarterly schedule.
348.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What percent of pharmacies are independent pharmacies and what percent of pharmacy costs are incurred at independent pharmacies?	See response to Question #37.
349.	RFP § IV(Q)(16) and Optumas Presentation at Bidder's Conference	153	What dispensing fee was assumed in the rate development for non-independent pharmacies?	Non-independent pharmacies were assumed to have a $2.50 dispensing fee.
350.	RFP § IV(Q)(16)(a)	153	With respect to pharmacy reimbursement, the RFP states the Dispensing Fee must be consistent with the current Medicaid FFS rate for independents. Are we correct to interpret that the MCOs can manage the national network ingredient cost for all	The current Medicaid FFS rate for independent pharmacies must be provided for the duration of the contract. MCOs may manage and negotiate the network ingredient costs but must provide the dispensing fee in addition to this reimbursement for independent pharmacies, unless an alternative reimbursement arrangement is otherwise agreed to by the pharmacy.

			pharmacy providers (e.g. AWP discount, MAC), as long as the dispensing fee requirement to mirror FFS dispensing fees is in place for independents for 6 month as required?	
351.	RFP § IV(Q)(16)(a)	153	The MCO's dispensing fee reimbursement must be, at a minimum, the current Medicaid FFS rate for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider. Does this mean that if a pharmacy has accepted alternate rates to participate in a national network we can use that network and those rates? What is the current FFS dispensing fee?	A MCO may not require a pharmacy to agree to rates already established in a separate contract. The MCO must obtain a new agreement, or addendum to existing agreement, from a participating Nebraska Medicaid Pharmacy Provider prior to the start of services under this RFP even if that pharmacy has an existing relationship with that MCO (IV.I.8.b.). The current dispensing fee is $4.45, but is subject to change
352.	RFP § IV(Q)(16)(a)	153	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum	The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, with methodologies limited to state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

			allowable cost, national average drug acquisition cost, or the submitted usual and customary charge. Are these examples of particular pricing methodologies, or intended to be the only types allowed? Will AWP discount networks be allowed?	
353.	RFP § IV(Q)(17)(c)	153	There is a requirement that the MAC must be available and searchable on the MCO website. There is also a requirement to post the provider manual. Can these requirements be satisfied through the PBMs secure provider portal as MAC/network management is a delegated function of the PBM?	This is acceptable.
354.	RFP § IV(S)(17)	176	"Does Nebraska Medicaid always pick up the patient responsibility"" or are there situations in which Medicaid would not pay the patient responsibility such as Medicare payment exceeds Medicaid amount? If Medicare pays less than the Medicaid amount and the patient responsibility amount	Applicable regulations are available at 471 NAC 3-004.04-05. Medicaid pays the deductible and coinsurance for Medicare-covered services. The amount received from Medicare for Medicare-covered services and other TPR and/or Medicaid for deductible and/or coinsurance shall not exceed Medicare allowable amount. Medicaid payment is the lower of the provider's usual and customary charge or the Medicaid allowable less all third party payment. When a claim is submitted to Medicaid with a payment from a third party resource, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the Medicaid allowable amount. The provider may only

			is less than the difference between the primary payment and Medicaid allowed amount, it the patient responsibility amount paid? Are there any situations in which the secondary payment would exceed the patient responsibility e.g. always paying up to the FQHC encounter/PPS rate?" "	bill the client for a Medicaid non-covered service, or Medicaid copayment fees, where applicable, or if the client has received payment from the TPR.
355.	RFP § IV(T)(2)	177	"We have two questions associated with this provision: (1) Is there a particular form or format MLTC wishes MCOs to use when submitting the disclosures under 42 CFR 455.100 – 455.106? In particular, we note that § IV(T)(1)(b) states that the "State will not review a deliverable unless the format and content has been approved in advance." (2) Please confirm that this disclosure may be submitted confidentially and will not be posted publicly. The	Disclosures may be submitted confidentially and will not be posted publicly. Section IV.T.2 is hereby amended as follows: "Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The MCO must disclose to MLTC this information at contract award, annually thereafter for each contract year, and within 30 calendar days of any change in the MCO's management, ownership or control."

			disclosures required by 42 CFR 455.100 – 455.106 include Social Security Numbers and dates of birth."	
356.	RFP § V(A)(2)(b)	196	"We have two requests for clarification regarding this section: (1) This requirement states that bidders must provide three years of financial statements. Please confirm that, where the bidder is a newly-formed subsidiary of a publicly traded company, three years of financial statements for the publicly-traded parent company will fulfill this requirement. (2) If publicly held, the bidder is required to provide a letter from ""the fiscally responsible representative of the bidder's financial or banking organization"". Please confirm that a bank reference from a bank officer would satisfy this requirement."	"(1) A newly-formed subsidiary of a publicly traded company that has fewer than three years of independently audited financial statements available should provide such statements it does have available and three years such statements for the parent company. (2) The purpose of this requirement is for the State to obtain contact information for the fiscally responsible representative of the bidder's financial or banking organization, not a receive a "letter". Please comply with Section V.A.2.b as written.
357.	RFP § V	196-198	"Please provide additional details regarding the order in which proposal elements	The sections should be included as separate identified tabs within the bidder's proposal response. There is no such requirement for the order of sections.

			should be provided. RFP § II(N) and RFP § V indicate that the following elements should be in the order indicated: • Request for Proposal Form • Section III (Terms and Conditions) • Corporate Overview • Technical Approach (responses to Proposal Statements and Questions in Attachment 19) However, we note that none of RFP § II(N), RFP § V nor Attachment 19 give instructions for the submission of the following documents, each of which is required to be submitted with the proposal: • Form A (Bidder Contact Sheet) (RFP § § II(H), page 4, and III(X), page 16) • Certification of authorization to transact business in the State of Nebraska (RFP § II(P), page 6) • Certificate of insurance coverage (RFP § III(F)(5),	

			page 10) • Proposed deviations from the RFP, if any (RFP § III(R), page 14) • U.S. Citizenship Attestation Form (for individuals and sole proprietorships) (RFP § III(AAA), page 27) • Ownership and control disclosure (RFP § IV(T)(2), page 177) "	
358.	RFP § V(A)(3)	198	Can the MCOs provide supplemental attachments to support the technical approach above and beyond those outlined as required in Attachment 5 and Attachment 19?	See the response to Question #172.
359.	Attachment 15	1	"We request two points of clarification relating to the definition of “Qualifying revenue for the MLR calculation”. (1) Paragraph 3 indicates that qualifying revenue is “[t]he aggregate of revenue earned by an MCO and related parties, including parent and subsidiary companies and risk bearing partners under	See response to Question #310.

			this contract." Please confirm that no amounts would be double-counted as revenue based on this definition. For example, amounts received by MCO as premium and then paid to a related party in order to reimburse that related party for administrative costs would be counted as qualifying revenue only once. (2) Paragraph 3 indicates that qualifying revenue ignores "federal and state premium taxes and non-operating income." Please confirm that this includes amounts paid to MCOs to reimburse them for the Health Insurance Providers Fee (see § IV(P)(7) on page 145)."	
360.	Attachment 15	1	For the purposes of calculating the MLR as described in Attachment 15, is the amount of payback of any profit in excess of 3% added to the numerator in the calculation? That is, does the definition of net qualified medical expense include dollars paid back to the state for profits exceeding 3%?	The MLR reconciliation will be calculated first, and any recoupments/paybacks will be factored into the 3% risk corridor calculation.

			Likewise, if the MCO receives a payment from the state because losses were greater than 3%, is that amount excluded from the numerator in the calculation?	
361.	Attachment 19	5	Question 31 Member Services Are the examples of information that will be available on the website and on portals for members included in the page count?	See response to Question #124.
362.	Attachment 19	5	Question 35 Member Services. The question asks us to "Attach examples" of member education material used with Medicaid or CHIP populations. Are these attachments included in the 10 page count?	See response to Question #125
363.	Attachment 19	5	Question 36, Please confirm that the 3 page limit to this response does not include the required flowcharts.	See response to Question #126.
364.	Attachment 19	8	Question 47, Provider Services: Are the requested sample provider outreach methods included in the 4 page count?	Example provider outreach methods will not be counted in the page limit. See response to Question # 119.
365.	Attachment 19	11	Question 59, This question requires that the bidder submit its proposed template for the health risk	See response to Question #127.

			assessment. Please confirm that this template would not be included in the page limits for this question.	
366.	B Eligibility for Enrollment (4)(a)(i) 7 Disenrollment , C (i)(a) 12 Audit Requirement (18) Moral or Religious Objections Glossary	p. 34 p. 37 p. 42 ix to xviii	If the MC) is not to discriminate on the basis of "religious beliefs" enrollment and provider claims should not be denied for "moral or religious beliefs", or "moral or religious objections" or "moral or religious grounds" or similar formulations and noting "moral" does not appear in the glossary, should not all such language be eliminated from the RFP?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. IV.C.i.a fulfills federal regulatory requirement 42 CFR 438.56(d)(2) regarding member disenrollment. IV.C.18 fulfills federal regulatory requirements 1932(b)(3)(B)(i) and 42 CFR 438.102(a)(2) regarding MCO responsibility when it has a moral or religious objection to providing a covered benefit or service.
367.	7 Disenrollment, C (i) (e)	p. 37	If the member may initiate disenrollment for cause under (e) "other reasons including but not limited to poor quality of care or lack of access to providers experienced in dealing with the member's health care needs", should this not these particular requests become, with sanctions a data point analyzed quarterly or otherwise tracked because quality of care and access to experienced providers are the core purpose of this RFP and subsequent contract.	Cause for disenrollment is a federal requirement addressed in CFR 438.56, Disenrollment: Requirements and limitations. MLTC will monitor contracts and apply Liquidated Damages and Intermediate Sanction when contract requirements are not met.

368.	Terms and Conditions S Slip law copy LB605 Sec. 108(2)(a) 4. (c)(ii)	p. 14 p. 48-49 p. 35	Is it not true that LB605 Section 108 (2)(a) "Medical assistance under the medical assistance program shall be suspended rather than cancelled or terminated for a person who is an inmate of a public institution"…. and incarceration is not a cause for disenrollment.	See Addendum 3 – Revisions to the RFP.
369.	Terms and Conditions S 4. (c)(i)(ii)	p. 14 p. 35	Should not "involuntary commitment" be removed as a cause for disenrollment when persons whose disenrollment has not been suspended and who are not in a public institution?	See Addendum 3 – Revisions to the RFP.
370.	Heritage Health Heritage Health	Slide 14, item 3 Slide 19, item 4	If the MCO is to adhere to these program goals and principles of care would not it follow that the 10 components of Recovery below, (commentary included for context), be included as an amendment? NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY (contd)	Section IV.L.3. addresses the requirements the MCOs must follow for recovery-based care which include the nationally recognized ten components of recovery.

			BACKGROUND Recovery is cited, within Transforming Mental Health Care in America, Federal Action Agenda: First Steps, as the “single most important goal” for the mental health service delivery system. To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and	

			reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings. Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. “THE 10 FUNDAMENTAL COMPONENTS OF RECOVERY • Self-Direction: Consumers lead, control, exercise choice over, and determine their own	

			path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals. • Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health. • Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that	

			will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life. • Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and	

			society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports. • Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery. • Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive,	

			trust-based relationships. • Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. • Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives. • Responsibility: Consumers have a personal responsibility	

			for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness. • Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make,	

			ultimately becoming a stronger and healthier Nation." The National Consensus Statement on Mental Health Recovery was funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.	
371.			Definition of Primary-care provider (PCP): ....Advanced practice nurses (APNs)...may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology. Comments: --Earlier this year, LB 107 removed all statutory requirements for physician supervision of nurse practitioners (NPs) in	See response to Question #2.

			Nebraska. As written, it would seem that the preceding definition is no longer consistent with changes in the law that became effective September 1, 2015. --There is no statutory definition for Advanced Practice Nurses in Nebraska. Nurse practitioners are one of four groups of Advanced Practice Registered Nurses (APRNs) which also include Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Clinical Nurse Specialists (CNSs). --In this definition, it appears that it is intended that both NPs and CNMs qualify as PCPs. Nurse midwives have different statutory requirements for physician oversight of practice. It may be appropriately stated that practice for NPs and CNMs as PCPs must be consistent with requirements for state licensure and statutory provisions within each profession's Practice Act. --Nurse practitioners must be	

			certified in specialty practice to obtain licensure. Those individuals practicing in primary care may be certified in adult, family, pediatric or women's health specialties.	
372.			Primary care services: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them. Comments: --As written, this definition excludes health care and laboratory services provided by advanced practice nursing providers, i.e., NPs and CNMs who qualify as primary care providers (PCPs) in the preceding section.	See response to Question #2.
373.			Provider requirements for a PCMH. Comments:	See response to Question #2.

			--As written, is it the intention to exclude NPs? This seems an oversight, considering 1. The removal of requirements for physician supervision that occurred with LB 107; 2. Nurse practitioners provide a significant portion of primary care services to rural and underserved populations in the state; and, 3. There is evidence to support NPs as PCMH providers, as well as health care providers with outcomes that meet or exceed those of physicians for equivalent services.	
374.	II. Procurement Procedures, H. Submission of Proposals	2	Please provide instructions on how to include any attachments we'd like to add to support our responses to questions in Attachment 19.	Attachments should be included within the applicable section or as separate identified tab(s) within the bidder's proposal response.
375.	IV. Project Description and Scope of Work O. Program Integrity 13. Monthly Reporting to MLTC iii	139	There appears to be a portion of this requirement missing for iii. Please confirm if this is to remain blank.	MLTC confirms that the requirement for iii. is to remain blank.
376.			Should not Medicaid Rehabilitation Option (MRO) be used liberally for individuals with functional and	The State is not mandating the use of a specific set of criteria for use of the Medicaid Rehabilitation Option.

			neurocognitive deficits, generally diagnosed with severe mental illness (SMI) or severe and persistent mental illness (SPMI), who need rehabilitative assistance with such daily living tasks as household management, communication, finances, transportation and comprehension/planning who need rehabilitation services, (e.g. skills training) and other rehabilitation services through MCO?	
377.	B 4 (c) (a)(i)	p. 34	Why should “disability” not be included in the definition of “MCO must not discriminate”…, as ‘disability” is the norm in non-discrimination clauses and should be included as a matter of equity and with reference to the federal law, Americans with Disabilities Act, ADA?	IV.B.4.a.i fulfills federal regulatory requirement 42 CFR 438.6(d) regarding prohibitions against enrollment discrimination. The prohibition against discrimination on the basis of health history, health status, and need for health care services is inclusive of members with disabilities.
378.	B 4 (c) (a)(i) B 2 (c)	p. 34 p. 33	Will all materials, e.g. member guidebook, plan matrix, provider directory and any program or other materials be made available in alternative formats and publicized in a way that members who need	Yes. The State will address this via the contracted enrollment broker. This is outside the scope of this RFP. However, the enrollment broker services RFP will be bid out at a later date.

			alternative formats know these materials are available and accessible to them?	
379.	Glossary	p. ix	If “advance directives” are used, are they part of an education and publicity program so that individuals are aware of them, create them correctly and include specific behavioral health and medical issues and are individualized for personal needs, such as a pet needing to be fed, flowers watered, etc., recognize that this is a legal document to be stored in a safe place, are assisted in notifying and leaving a copy with all their providers, and are offered whatever assistance the individual needs to have the Advance Directive honored in its entirety, is this available within the scope of this process?	Please see Section IV.F.12 of the RFP.
380.			Will there be an “Ask a Nurse” by whatever name but retaining the function, be created and available cost-free, and publicized to the members within the scope of this process?	See Section IV.F.2 Member Services Call Center.

381.			LB107 was passed and made into law in 2015, eliminating the need for Nurse Practitioners to be supervised by a Physician, yet the definition of Primary Care Provider (PCP) in the RFP references that old system: "Primary care provider (PCP) : A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology." Additionally, on the	See response to Question #2.

			requirements for the Primary Care Mental Health (PCMH) practice – am I reading it correctly that in order for a practice to qualify, that it must include a physician? Again, NPs in Nebraska can now practice without physician supervision as per LB 107 and are providing significant portions of primary care services particularly in the rural areas of our state. There is substantial research supporting NPs as PCMH providers. I am hopeful this is an oversight in the proposed RFP and that NPs are included in the PCMH definitions.	
382			I wanted to know if Non-Emergency Transportation (NEMT) was going to be included in this procurement, or if it was going to be procured separately.	Please see response to Question #82.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM SIX
QUESTIONS and ANSWERS

Date: November 18, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Due to the high volume of the questions, the state is providing the rsponses to questions 1 – 220 at this time. The State will provide responses for the remaining questions at a later date.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			Our organization is most certainly equipped to do the full-risk physical health managed care program, but we would partner for behavioral and pharmacy. Would this arrangement be acceptable to you?	While the RFP does not prohibit sub-contracting, it does require that MCOs deliver an integrated approach to service delivery and care management.
2.			We have been reviewing the RFP for Medicaid, and it would be very helpful if we could have clarification on the definition of PCMH and also on which provider types can be primary care providers. With the passage of LB 107, NPs no longer have collaborative or supervisory agreements with physicians. So under this definition, NPs would not qualify. NPs offer a great opportunity for patient centered medical homes and also to be defined as a covered primary care provider under Medicaid, which increases the access for this vulnerable population. "Primary care provider (PCP)A medical professional chosen by or assigned to the	See Addendum 3 – Revisions to the RFP.

			member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology"	
3.			LB 107 was passed into law the last legislative session whereby Nurse Practitioners (NPs) in Nebraska no longer need physician supervision. The law became effective September 1st of this year. If you could explain the inclusion of NP supervision in the RFP (see below) it would be appreciated. It appears that LB 107 would render this	See response to Question #2.

			definition inconsistent with NP practice law: "Primary care provider (PCP) A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology" Additionally, on the requirements for the PCMH practice – am I reading it correctly that in order for a practice to qualify, that it must include a physician? Again, NPs in Nebraska can now practice without physician	

			supervision as per LB 107 and are providing significant portions of primary care services particularly in the rural areas of our state. There is research supporting NPs as PCMH providers. I am hopeful this is an oversight in the proposed RFP and that NPs are included in the PCMH definitions.	
4.	Section II(H), Submission of Proposals; Section III(NN) Proprietary Information	p. 4; p. 23	Please confirm that the State will await the outcome of any objections, legal challenges, or litigation in connection with a FOIA request to obtain proprietary, confidential, or trade secret information submitted in accordance with the instructions in this section before releasing it.	The State will not contact the bidder before responding to a FOIA request. The State will withhold the appropriately identified copywritten materials and proprietary information as identified by the bidder.
5.	Section II(H), Submission of Proposals; Section III(NN), Proprietary Information	p. 4; p. 23	Please confirm that proprietary or confidential information submitted in accordance with the instructions in Section III of the RFP will not be posted for public viewing even if the State disagrees with a bidder's assertion that the information is protected as confidential, proprietary, or a trade secret.	Appropriately identified copywritten materials and proprietary information will not be posted for public viewing. See the response to Question #4. Per Section III, NN Proprietary Information, “Bidders may not mark their entire Request for Proposal as proprietary.”
6.	Section II(H), Submission of	p. 4; p. 23	Please confirm that "non" should be inserted before the	The following language is hereby amended as follows: IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02,

	Proposals; Section III(NN), Proprietary Information		word "confidential" so that this statement should read as follows: "The language above should read "All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING."	all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or non-confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING.
7.	Section III(E), Ownership of Information and Data	8-9	Some Contractors may have license agreements with other companies for the use of certain proprietary computer software programs. Please confirm that the State of Nebraska will not require Contractor or any subcontractor to violate any aspect of license agreements or other contracts they may have with other companies for the use of certain proprietary computer software programs or make any modification to the proprietary software included in such license agreements or other contracts.	This section requires the Contractor to either own the license or obtain a license to utilize the software or other copywritten material the Contractor intends to use to perform under the contract. Any costs associated with license(s) will be the responsibility of the Contractor.
8.	Section III(E), Ownership of Information and Data	pp. 8-9	Please confirm that the State of Nebraska will not publish, duplicate, use, or disclose a Contractor's confidential, proprietary, or trade secret information without giving the	Subject to State law and the posting of contracts, it is the responsibility of the bidder to properly identify proprietary information as defined by the Nebraska State Statutes. See the response to Question #5.

			Contractor advance notice of its intention to do so and awaiting the outcome of any objection, legal challenge, or litigation that may occur as a result of the Contractor defending its position regarding the confidential and proprietary nature of the information to any appropriate State agency, Court of competent jurisdiction, or in any other appropriate venue.	
9.	Section III(E), Ownership of Information and Data	8-9	Please confirm that the intention of the State is not to have the unlimited right to publish, duplicate, use, and disclose Contractor's intellectual property, confidential, and proprietary information, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding.	See response to Question #8.

10.	Section III(CC), Administration-Contract Termination; Section III(NN), Proprietary Information	19	Please confirm that the deliverables and/or data and documentation contained in the proposal that shall become the property of the State under either of these provisions do not include intellectual property, confidential, or proprietary information used or to be used in connection with work performed on this Contract, including, but not limited to, inventions, patents, copyrights, trademarks, trade secrets, trade names, operating systems, policies, proprietary aspects of computer systems, proprietary computer software programs, proprietary software computer system design documents or other system documentation, and coding and that upon completion or termination of the Contract, Contractor will be able to retain such information for use in connection with work on other current and future Medicaid contracts nationwide.	If a deliverable is created for the State as required by the contract, then the State owns the deliverable.
11.	III.EE.1 Performance Bond	19	Is the $50,000,000 performance for each region or statewide?	The performance bond is statewide per awarded Contractor.

12.	Section III(NN), Proprietary Information	23	If a particular page of a bidder's proposal or exhibit thereto contains proprietary information, but the page in its entirety is not proprietary, should the bidder redact the proprietary information and submit the remainder of the page with its proposal and then include an unredacted copy in a sealed envelope? If this is not the proper procedure, please explain what process bidders should use when submitting proprietary information included on a page that also contains non-proprietary information.	The bidder may submit the redacted version within the technical response and submit the proprietary information in a separate sealed envelope in accordance with Section III. NN Proprietary Information. See the response to Question #5.
13.	Section III(EEE), License/Service or Other Agreements Section V(A)(2)(j), Sub-Contractors Attachment 5	28-29; 198; Attachment 5, p. 2	Since Section V(A)(2)(j) does not require the bidder to submit subcontractor agreements with the subcontractor information to be submitted with the bid and since Attachment 5 states that subcontracts are to be submitted for review and approval 90 days prior to the contract start date, please confirm our understanding that the "service or other such agreements" that must be submitted with the bid under Section III(EEE) if bidders	Yes, Section III (EEE) does not include bidder agreements with subcontractors.

			wish the State to consider them do not include agreements with subcontractors for the performance of a service or function related to the fulfillment of an MCO's obligations under the contract and that therefore subcontract agreements are not subject to any of the requirements in Section III(EEE).	
14.	Section III(EEE), License/Service or Other Agreements; Section IV(I)(12)(b), Provider Outreach and Application Processing;	28-29; 100	Since Section IV(I)12)(b) addresses what must be submitted with the bid with respect to provider templates, please confirm that the "Service or other such agreements" that must be submitted with the bid if bidders want the State to consider them do not include provider agreements and that therefore provider agreements are not subject to the requirements of this provision.	Provider agreements are not subject to the provision set forth in Section III(EEE).
15.	Section III(EEE), License/Service or Other Agreements	7; 28-29	Please confirm that the State will not view the submission of all "license/service or other agreements" as proposed alterations to the Terms and Conditions but only those that actually conflict with or alter	Any terms and conditions, user agreement, or other document or clauses offered or purport to be included as a part of this RFP shall be subordinate to the original RFP. The Bidder shall specify which clauses the Bidder proposes to incorporate into the contract; documents will not be incorporated in their entirety unless the Bidder states the document is proposed in its entirety. For Bidder proposed clauses to be binding, the State

			the State's Terms and Conditions.	must acknowledge and accept the clause in writing.
16.	Section III(EEE), License/Service or Other Agreements	28-29	Since a reading of contract provisions is subjective and open to interpretation and since the State may view a provision in a license/service or other agreement as conflicting with or altering the State's Terms and Conditions, when the bidder did not intend to alter those terms at all, please confirm that if a bidder submits a "license/service or other agreement" with its bid that the State interprets as conflicting with or altering the State's Terms and Conditions, the State will notify the bidder and provide it with an opportunity to cure the alleged conflict or alteration before determining that the license/service or other agreement is a proposed alteration of the Terms and Conditions that may be cause for a rejection of the bidder's proposal.	Subject to the response in Question #15, the State will compare the terms offered by the bidder to the terms of the State.
17.	Section III(EEE), License/Service or Other Agreements	28-29	Please list examples of the types of "license/service or other such agreements" that must be submitted with the bid under this provision.	Examples may include a service level agreement, user agreements, license agreements and bidders supplemental conditions to the State's Terms and Conditions.

18.	IV.A.1.c Description of Current Program	30	Will these 40,000 individuals that are currently in BH managed care but not PH managed care be enrolled with an MCO starting on 1/1/17? What is the cost by category of service on a PMPM basis for this population in FY 14 and FY 15?	Yes, the individuals currently in BH managed care but not currently in PH managed care will be enrolled in an MCO on 1/1/17. These individuals are categorized in the LTSS (Institutional) – Dual, LTSS (Institutional) - Non-Dual, LTSS (Home and Community Based) – Dual, LTSS (Home and Community Based) - Non-Dual, and Dual aid categories. The FY14/FY15 combined expenditures by services category have been provided for these populations as Attachments 10-C and 10-D.
19.	IV.A.10.h Included Populations	32	How far back will retroactive enrollment be allowed? How will DHHS ensure that MCOs that receive a disproportionately higher percentage of these retroactive members are compensated appropriately?	Retroactive enrollment will be no earlier than the contract start date. The MCO will receive a capitation payment for each month of retroactive enrollment.
20.	IV.A.10.h Included Populations	32	Can DHHS add an indicator on the eligibility file that will designate whether a member is a regular enrollee, an immediate enrollee, or a retrospective enrollee? How were these three cohorts taken into account in rate development?	If the EBS or MMIS has access to this information, it can be added to the file. Current rates do not account for retroactive enrollment. Immediate enrollment is inherent in 17 months of the base data. The remaining 7 months are adjusted to account for immediate enrollment. The adjustment value was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented. Regular enrollees are fully inherent in the base data.
21.	IV.B.4.d. Eligibility and Enrollment (d)	35	Will all newborns be assigned to the same MCO for multiple births?	The Heritage Health Enrollment Broker will facilitate the assignment of multiple births to the same MCO for continuity of care.
22.	D.3. a. and b, 3. Additional Required	50	Are the MCOs permitted to use independently licensed	Yes.

	Staff		behavioral health practitioners to perform prior authorization and concurrent review?	
23.	IV.E.8.b. Rehabilitation services - iv.i)	57	Please provide the definition for Assertive community treatment (ACT) and Alt ACT.	See http://dhhs.ne.gov/medicaid/documents/act.pdf
24.	IV.E.11. Pharmacy Services - c. Nebraska Medicaid Preferred List	59	Can the timeframe be adjusted to 3 business days, by allowing the extension it would provide for adequate testing and quality processes.	Upon initial receipt of the file, an extension of three business days would be acceptable, but thereafter, the file must be uploaded in one business day.
25.	IV.F.13. Communication with New Members, b.ii.	80	Will the MLTC enrollment file list the "responsible party" for each new member? If not, can you explain what methods should be used to determine who is the "responsible party"	Yes, this information will be provided via the enrollment files.
26.	I. PROVIDER NETWORK REQUIREMENTS, 14. Provider Credentialing and Re-Credentialing	100	Currently the TAT for NE Medicaid is that of 45 days from the date of the receipt of a completed application thru Committee review/decision. For the expansion RFP for physical health, behavioral health and pharmacy, the state has a 30 calendar day TAT. Is the state willing to approve a 45 day TAT from receipt of a completed application to match what is currently in place for the NE Medicaid medical providers?	The 30 day TAT requirement will remain as written in the RFP.

27.	IV.L.4. Basic CM Services, e, viii	115	Does the state expect the MCOs to facilitate the development of group visits or help members participate in the existing group visits?	MCOs must facilitate the development of group visits for members assigned to high risk care management.
28.	IV.L.6.b Special Considerations for Pregnant Members	116	What is considered adequate? Is there a specific ratio the MCOs must adhere to?	There are no specific ratios that are required by the MCOs. Attachment 2 includes provider network access standards.
29.	IV.N.5. Service Authorization for Pharmacy Services	128	Please clarify what is meant in 5.a.iii by "Process Supporting Tables"	"Process supporting tables" references any proprietary table(s), resource table(s) or any other reference guide(s) used in the evaluation of the call center team for determining approval, denial or dose recommendations of medications.
30.	IV.P.2.i Capitation Rate Determination Process, i	143	What is the net rate increase comparing the current managed care rates to the RFP rates on an apples to apples benefit basis -- ignore pharmacy, behavioral health, and LTSS rate cells? What is the trend that was applied? How does this trend compare to the actual managed care trend experience from FY 2014 to FY 2015?	Growth rates for the current managed care rates in physical health from FY2014 to FY2015 are influenced by policy decisions such as immediate enrollment. This is expected to be a one-time impact, as such the assumed growth rates as indicated in the RFP and will commensurate with historical growth rates seen in the program.
31.	IV.P.4. Transplant Services	144	Will there be separate compensation for transplants? Case rate?	Costs associated with transplants are carved into the base data and are included in the capitation rates shown in Attachment 11. There will not be a separate case rates paid for transplants.
32.	IV.P.8.a Risk Adjustment	145	What risk adjustment methodology will be used after the first contract year? We recommend a methodology that is widely used and includes pharmacy	MLTC will work with the Actuaries and the MCOs in determining the best risk adjustment tool for the Heritage Health program.

			encounters such as CDPS + Rx.	
33.	IV.P.9.c Risk Corridor	146	Can you please define the qualifying revenue? Will the qualifying revenue exclude the 1.5% QPP hold back?	See Page xv of the RFP for the definition of qualifying revenue (for the risk corridor calculation). Since the 1.5% QPP hold back is not considered earned income, it will not be included in the risk corridor calculations.
34.	IV.P.11.c. State Performance Penalties	147	Please confirm that the provisions to appeal liquidated damages assessments identified in Section 2.i. on page 184 apply to this provision.	The provisions in Section IV.V.2.i would apply to the liquidated damages listed in Section IV.P.11.c.
35.	6. Value-Based Contracting, c.	150	Please define "risk- sharing".	Risk is defined as the chance or possibility of gain or loss associated with caring for a given population. A MCO awarded under this RFP will be at risk for whatever volume of care is provided to its members. A risk-sharing agreement with a network provider is one in which the MCO transfers some portion of risk to a network provider, such as payment of a fixed rate for which the network provider is to provide or arrange care for an assigned group of members.
36.	IV.Q.15 Payment for Emergency Services	153	Please clarify the definition of a "medical emergency."	The definition of "medical emergency" is synonymous with the definition of "Emergency medical condition", which can be found in the Glossary of Terms on page xi.
37.	IV.Q.16.a Pharmacy Reimbursement	153	What is the average dispensing fee for non-independent pharmacies? What is the percentage of non-independent pharmacies assumed in the rate development? What is the basis for the dispensing fee reduction estimate in the rate	Non-independent pharmacies were assumed to have a $2.50 dispensing fee and independent pharmacies were assumed to have a $4.45 dispensing fee. The independent pharmacy dispensing fee is the State FFS dispensing fee set for independent pharmacies. The $2.50 non-independent pharmacy dispensing fee is based on discussions with the state and research of other states. In Rating Region 1, 85% of prescriptions were filled by non-independent pharmacies. In Rating Region 2, 58% of prescriptions were filled by non-

			development?	independent pharmacies.
38.	IV.Z.1 Claims Broker Services	192	What is the current administrative cost paid on a per claims basis by DHHS? How will the per claim administrative fee paid to the CBS be determined?	Due to the current MMIS system, the State does not have current administrative costs paid on a per claim basis. Please see RFP Section IV.Z.1 for determination of the administrative fee paid to the CBS.
39.	V(A)(2)(e), Relationships with the State	197	Please confirm that for purposes of this question "any dealings with the State" is limited to contracts entered into with the State or other projects or initiatives the bidder, its organization, or any predecessor or party named in the bidder's proposal has worked on with the State in the last five years, and does not include day-to-day contact with State personnel related to existing contract requirements, obligations, or administration.	Section V.A.2.e pertains to contracts entered into between the State and the bidder.
40.	V(A)(2)(g), Contract Performance	197	Please confirm that contracts terminated for default must be reported for bidders and any proposed Sub-Contractor, but information regarding contracts terminated for convenience, non-performance, non-allocation of funds or any other reason, is required of the bidder only,	Per Section V.A.2.g, the bidder must provide if they or any proposed sub-contractor has had a contract terminated for default during the past five (5) years as detailed in this section. The bidder must provide if they have had a contract terminated for convenience, non-performance, non-allocation of funds, or any reason.

			since in the ordinary course of business contracts terminate for reasons other than default every day and requiring this information of each subcontractor could result in inundating the State with volumes of information.	
41.	V(A)(2)(g), Contract Performance	197	To avoid inundating the State with information for lines of business unrelated to the current RFP, please confirm that the State is seeking information regarding terminations of contracts for services related to Medicaid/CHIP programs only.	Per Section V, A, 2, g, “It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder’s position on the matter.”
42.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Is this question seeking two separate items: (1) a summary matrix; and (2) narrative project descriptions; or, is this question seeking one item (e.g., a summary matrix of bidder's experience in a tabular format to include the information requested in subparts (a)-(e) above)?	The summary matrix should consist of the items listed in subparts a – e.
43.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that the "summary matrix" sought in this question should be in tabular form and include the information enumerated in subsections (a)-(e).	The summary matrix may be in a tabular form.
44.	V(A(2)(h), Summary of	197	Please confirm that the	The bidder may submit more than three (3) projects, but the State

	Bidder's Corporate Experience		"summary matrix" sought in this question, which bidder is interpreting as a tabular summary of its experience to include the items listed in subsections (a)-(e), can include more than three projects.	will use no more than three (3) narrative project descriptions. The bidders are discouraged from submitting more than three (3) project descriptions.
45.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	For what time period or "look back period" should bidders report the information requested in this section?	The State does not identify a time period.
46.	V(A)(2)(h), Summary of Bidder's Corporate Experience	197	Please confirm that bidders are permitted to provide more than three (3) narrative project descriptions of other projects and experience from which the State will then choose no more than three (3) on which to evaluate the proposal.	See the response to Question #44.
47.	V(A)(2)(h)(i)(e), V(A)(2)(h)(ii), and V(A)(2)(h)(iii) Summary of Bidder's Corporate Experience	198	Please confirm that the reference to "Sub-Contractors" and "Sub-Contractor(s) experience" refers only to bidders' experience as a subcontractor, as opposed to a primary contractor, on similar projects and that bidders are not required to provide summary matrices and/or narrative project descriptions regarding previous similar projects for	Corporate Experience is the bidder's role as the prime Contractor and/or as the role of the Sub-Contractor.

			each of their proposed subcontractors.	
48.	Attachment 11 – Rates	Attachment 11	In the effort to maintain transparency, can DHHS share the capitation rate calculation sheet that was used to trend the base data and adjust it to the rates in Attachment 11?	See Attachment 20: "COA-level Rate Development" for the step-by-step development of the rates at a COA level.
49.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12	Please provide the transplant data separated by year. Has there been an increase in transplants in recent years versus earlier years? How has this been accounted for? By placing the transplant costs in the capitation rates, how will DHHS avoid underpricing the transplant costs for an MCO that receives a disproportionate share of overall transplants? We recommend a transplant kick payment instead of an adjustment to all members' capitation rates to more equitable compensate MCOs for their incurred costs. We also recommend transplant kicks that vary by type of transplant -- heart, bone marrow, lung, intestine, kidney, or pancreas/kidney.	Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. MLTC does not intend to use a transplant kick payment. Bidders may purchase reinsurance or take other appropriate steps to mitigate the risk of fluctuation in the costs of transplants.
50.	Attachment 19, Proposal Statement	Attachment 19, p.1	Please confirm that the information sought from	The information sought is that related to Medicaid or CHIP contracts.

	and Questions, No. 2		bidders' parent company, affiliates, and subsidiaries in response to Question 2 includes only regulatory actions, monetary or non-monetary sanctions, letters of deficiency, and corrective actions related to Medicaid/CHIP contracts.	
51.	Attachment 19, Proposal Statements and Questions, No. 3	Attachment 19, p.1	Please confirm that the information sought from bidders' parent company, affiliates, and subsidiaries in response to Question 3 includes only investigations related to Medicaid/CHIP business.	See response to Question # 50.
52.			As a business owner this who would like to be able to accept Medicare and Medicaid patients someday, the language of this is limiting and very concerning to me. "Primary care provider (PCP)A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family	See response to Question #2.

			practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN).Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology" I am a Family Practice Nurse Practitioner. I own my own practice and provide care to over 300 patients. As Nebraska law allows, I do not have a supervising physician. I would like to be able to accept both Medicare and Medicaid insurance someday, but as of yet, they are not in agreement with Nebraska law. Thank you for taking this matter into your immediate consideration.	
53.	Glossary - Related-party	xv	The examples provided for "related-party" include "subcontractors to the MCO	Related-party: The parent company of a MCO or an entity partially or wholly owned by the MCO or the MCO's parent company that receives any revenue from the MCO for Medicaid

			performing services under this contract." Please clarify that this would apply only to subcontractors owned, either wholly or partially, by the MCO or its parent company and not to third party subcontractors.	contracted services. Examples of related parties include a clinic wholly or partly owned by a MCO or its parent company that provides services covered by Nebraska Medicaid and subcontractors to the MCO performing services under this contract. Yes, it relates to subcontractors wholly or partially owned by the MCO or its parent company. This does not include independent third party subcontractors.
54.	Request for Proposal for Contractual Services Form; IV.H-Submission of Proposals; IV.NN-Proprietary Information	i, 4, 23	"All non-proprietary or confidential information as defined by Law WILL BE POSTED FOR PUBLIC VIEWING." Should this read, "All non-proprietary or NON-confidential information…?"	See response to Question #6.
55.	II.H Submission of Proposals	4	Please verify that the Bidder must submit only one copy of the original proposal and that an electronic copy of the response is not required.	The bidder must submit one original of the entire proposal response. An electronic copy is not required.
56.	II.H Submission of Proposals	4	Is there a font style and font size that the Bidders must adhere to when responding to this RFP?	There are no such requirements.
57.	II.H Submission of Proposals	4	Is there a specific section in the Binder where the Bidder should attach the additional forms - Form A, Contractual Services Form, and the Confidentiality Sheet - or should they be included in a separate tab(s)?	The Contractual Services Form, Form A, and the Confidentiality Sheet should be included as a separate identified tab within the bidder's proposal response.
58.	III Terms and Conditions	7	"… a bidder may indicate any exceptions to the Terms and	No, a statement recommending terms and conditions that

			Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. Would "a statement recommending terms and conditions the bidder would find acceptable "constitute a "rejection in whole or in part"?	bidder would find acceptable does not constitute a rejection. The bidder should provide alternative(s) for the State's consideration.
59.	III.J Contractor Personnel	12	"Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State." Please clarify whether this applies to any personnel changes (individual staff, staffing levels due to changes in membership, etc.) or if it can be limited to changes of substance (key personnel, general staffing ratios, etc.).	Per Section III, J Contractor Personnel, "Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications."
60.	III.II Taxes	21	"The State is not required to pay taxes of any kind and assumes no such liability as a	No. The Health Insurer Tax will be incorporated in future rate setting cycles.

			result of this solicitation." Does this provision extend to the Health Insurer Tax enacted through the Affordable Care Act?	
61.	IV. A.1.g.ii Description of Current Program	31	Would pharmacy services have a different start date than physical health services? Please confirm the expected start date for pharmacy services.	The anticipated start date for pharmacy services is January 1, 2017. The State reserves the right to adjust the start date of pharmacy services at its discretion.
62.	IV.4A.1.g.iii Description of Current Program	31	Are Aged, Blind, and Disabled persons, whether dually eligible for Medicaid and Medicare, in a home and community-based services waiver program, or living in an institution, included in managed care only for physical health services and not for behavioral health services or pharmacy services?	All populations included in Heritage Health will have the Heritage Health benefits package, including physical health, behavioral health, and pharmacy services. The ABD population (including those who are dually-eligible, those receiving HCBS services, and those living in ICF/DDs) is included in Heritage Health.
63.	IV.4A.1.g.iii Description of Current Program	31	This population will be included "for managed care physical health services"; will the MCO be responsible only for physical health services and not facility, behavioral health, NEMT or other services?	Section IV.A.1.g.iii is hereby amended as follows: "Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services."
64.	B.4.d.iii Eligibility and Enrollment - MCO	35, 144	Are there any time limits that would apply to enrollment and/or capitation payment	See response to Question #19.

	Enrollment Procedures IV.P.3.b MCO Reimbursement - Capitation Rates and Payment		retroactivity regarding both the enrollment transaction as well as the ensuing capitation payment?	
65.	B.5.g Eligibility and Enrollment - PCP Assignment	36	Please clarify whether it may be possible for a provider to participate with Medicare and not Nebraska Medicaid?	All providers must be Nebraska Medicaid enrolled to participate in or be reimbursed by the MCO.
66.	B.5.g Eligibility and Enrollment - PCP Assignment	36	If a dual eligible member is obtaining services from a non-par PCP, will the plan be required to continue paying for those services at the Medicaid fee schedule?	See Section IV.S.15.a.x. and Section IV.S.17 for requirements related to dual eligible members.
67.	B.6.b Eligibility and Enrollment - MCO Changes	36	Does this mean that, regardless of a member's anniversary date, their open enrollment period would always be in December?	For the duration of the contract, the annual enrollment period will take place in December for all Heritage Health members.
68.	IV.D.3.a & IV.D.3.b Staffing Requirements - Additional Required Staff	50	Are the requirements under section 3a and 3b referring to medical and pharmacy staff or just medical?	Sections 3a and 3b are referring to medical staff.
69.	IV.D.3.a & D.3.bStaffing Requirements - Additional Required Staff	50	Is Nebraska state licensure required for all Prior Authorization staff and concurrent review registered nurses, including Pharmacy?	MLTC will provide this answer in the second round of questions for this RFP.
70.	IV.4E.8.a.xix Covered Services and Benefits - Core Benefits and Services	55	What are the definitions of "skilled services", "rehabilitative services", and "transitional nursing facility services" which must be	These services are defined as those meeting requirements outlined in 42 CFR 409 Subpart D, Requirements for Coverage of Post-hospital SNF Care.

			provided as a minimum benefit package?	
71.	IV.4E.8.a.,IV.4E.28, Iv.4E.29.b & 4E.29.b Covered Services and Benefits - Core Benefits and Services, Medical Transportation Services, and Excluded Services	54-55 66-67	Custodial nursing facility services are listed as excluded services. What core benefits and services are MCOs to provide to members who are residents of nursing homes but are receiving custodial services? For example, are MCOs required to provide emergency and non-emergency ambulance services to such members?	A MCO is to provide all core benefits and services with the exception of those included in the nursing facility per diem. Services included in the nursing facility per diem can be found at 471 NAC 12-009.05 http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-12.pdf
72.	IV.4E.8.a, IV.4E.29.e Covered Services and Benefits - Core Benefits and Services and Excluded Services	54-55 66-67	Home and community based services are not included as a part of the core benefits or services. What core benefits and services are MCOs to provide to persons receiving home and community based services?	A MCO is to provide all core benefits and services to persons receiving home and community-based services.
73.	IV.E.11.b.ii Covered Services and Benefits - Pharmacy Services	58	Does this include any changes post 1/1/17? Does this include post P & T formulary changes? Please confirm what is considered a "change".	Any modifications of drug coverage must be submitted for review and approval at minimum 30 days prior to implementation. Notice may be less than 30 days during the first month of implementation.
74.	E.11.b.iv.c Covered Services and Benefits - Pharmacy Services	58	Please confirm that the posting of the MAC list would occur behind a secure channel for providers.	The State confirms that the MCO MAC list is not required to be posted publicly, but the MCO must maintain a website and post current and accurate information, including the MAC pricing, to be available to the State and provider network.

75.	E.11.b.i Covered Services and Benefits - Pharmacy Services	58	The language in this section states that all formulary policies and procedures must be submitted to MLTC for approval, but the RFP states that the MCO must follow the State's PDL. Please clarify as to when this scenario would occur.	See Glossary of Terms for the definitions of PDL and Formulary. The State's PDL is not an all-inclusive list of therapeutic categories. The MCO must cover the medications listed on the State's PDL, but will also need to maintain a formulary that covers medications not listed in the PDL. Refer to the following link for additional information: http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx
76.	E.11b.iv.a Covered Services and Benefits - Pharmacy Services	58	Please confirm that the MCO formulary would need to be posted on the website, since the MCO is required to follow the State's PDL?	The MCO will be required to post and maintain the most current and accurate MCO formulary on their website. The State PDL must also be posted.
77.	E.11.b.vi Covered Services and Benefits - Pharmacy Services	59	Given that newly available medications may not be available in First Data Bank, they cannot be coded or processed yet at the point of sale, so the MCO may not always be able to fulfill the 10 day requirement. Please clarify any exceptions to this requirement.	The MCO has 10 days to implement coverage after a new drug has been loaded on a National Drug Reference File.
78.	E.11.c.iii Covered Services and Benefits - Pharmacy Services	59	Please provide additional information on the volume of changes expected.	PDL files will be shared with MCOs on a weekly basis. Large-scale PDL possible changes occur biannually in conjunction with P&T meetings.
79.	E.11.c. vi Covered Services and Benefits - Pharmacy Services	59	Please clarify if this provision would prohibit the MCO from negotiating supplemental rebates, in addition to the Medicaid rebates that pharmaceutical companies	MCOs may negotiate supplemental rebates for medications outside of the State's PDL. MCOs are prohibited from negotiating supplemental rebates for any medications listed in the State's PDL.

			are required to provide.	
80.	IV.E.19.a Covered Services and Benefits - Limitations on Abortions	64	Confirm that MLTC Medical Director must also review all approvals for elective abortions prior to determination notification to the requesting provider. If so, (a) how does the plan send, (b) what is required to be sent to the MLTC Med Director and (c) what is the expected turnaround time from the MLTC Med Director? Also, who will provide reviews if the MLTC Med Director is out of the office?	The State is currently establishing this process and will be provided to the awarded contractors.
81.	IV.E.21 Covered Services and Benefits – Transplants	65	Is the MCO required to follow Medicare policies for transplants (i.e. - the RFP states that if Medicare does NOT have a policy the MLTC Medical Director will determine).	The MCO must cover transplants (including donor services) that are medically necessary and defined as non-experimental by Medicare. Per Section IV, E.21, "As required by 471 NAC 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental."
82.	IV.E.28.a Covered Services and Benefits - Medical Transportation Services	66	The section states that NEMT is only covered for medical transportation by an ambulance; however, the other NEMT are not listed under Excluded Services IV.E.29, page 66/67. Please clarify.	See Addendum 3-Revisions to the RFP.
83.	IV.E.29	66-67	Eligible populations include	The MCO is responsible to provide all services in the core

	Covered Services and Benefits - Transplants		“Medicaid beneficiaries who participate in a HCBS Waiver program"; however, all HCBS waiver services are excluded from MCO responsibility. Which party will be financially responsible for any HCBS services for waiver-eligible individuals that are assigned to a “wait-list?”	benefits package and any value-added services as approved by the State for its members. This responsibility is not affected by the member’s waiver status.
84.	IV.F.2.b.v, IV.F.2.xi. Member Services and Education - Member Services Call Center	69	Please confirm that the lines on Section IV.F.2.b.v and IV.F.2.xi were left intentionally blank.	The lines were unintentionally left blank. No requirements are missing or intended for these numbers.
85.	IV.H.7.a. and IV.H.7.c Member Services and Education - Access to State Fair Hearings	92	Please clarify if the member is required to exhaust the plan’s internal appeal process prior to submitting a request for a State Fair Hearing?	The member is required to exhaust the plan's internal appeal process prior to submitting a request for a State Fair Hearing.
86.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	"The MCO must strive to improve the ability of its behavioral health provider network to meet all the health needs of members through strengthened collaboration with PCPs, service providers, inpatient hospital providers, and consumer/peer providers.” Will the State allow providers to bill for same-day services for physical health and behavioral health visits when co-located in the same provider office?	Yes.

87.	IV.I.4.i Provider Network Requirements - Establishing the Network	96	Please further clarify what will constitute "collaboration with the DHHS Division of Behavioral Health and State behavioral health regions"	Collaboration will include, but is not limited to, a commitment by the health plan to participate in meetings or on committees that identify barriers and solutions that supports the level of care needed by Medicaid clients and other clients served by the Division of Behavioral Health.
88.	IV.I.13 Provider Network Requirements - Provider Enrollment in Medicaid	100	Please clarify whether a provider who has applied for MLTC enrollment but is not yet enrolled AND is credentialed by the MCO may see patients, or whether the MCO must wait until MLTC enrollment is complete.	MLTC enrollment must be complete in order for a provider to see patients. The MCO has the option to authorize services out of network until the MCO credentialing is complete.
89.	IV.J.3.a.ix Provider Services - Provider Handbook	104	Are the "medical record standards" to be included in the Provider Manual those that are reflected in the RFP (i.e. - applicable to MCOs) or are there separate regulatory requirements for physicians?	The medical records standards are to be included in the Provider Manual and must include all standards set forth in the RFP and all applicable regulatory requirements.
90.	IV.M.11 Quality Management - Member Advisory Committee	124	Please clarify who would be considered a member's representative, for purposes of fulfilling the requirements of the Member Advisory Committee.	See Page xvi in the Glossary of Terms for the definition of Representative.
91.	IV.M.12 Quality Management - Clinical Advisory Committee	124-125	Does the State intend for plan members to participate on this committee as well? There is a reference to "members" but it's unclear whether it is intended to mean members of the	Plan members will not participate in this committee. This reference to member refers to members of the committee.

			committee or members of the plan.	
92.	IV.N.2.f Utilization Management - UM Program Description	126	Please clarify the statement regarding involvement of "actively practicing", board certified physicians in the program to "supervise" ALL review decisions and review denials for medical appropriateness. Is it the intent of MLTC that this section is referencing the physicians that should participate in the Clinical Advisory Committee/UM Committee or actual practicing providers that are reviewing UM decisions?	Active practicing providers must supervise all UM review decisions and review denials for medical appropriateness.
93.	IV.N.11.b Utilization Management - Restricted Services	131	Please confirm the type of restriction program: pharmacy, provider, or both?	See NAC 471 NAC 2-004 for categories of pharmacy and provider restriction. http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-02.pdf
94.	IV.O.1.h Program Integrity - General Requirements	133	The RFP states that "The MCO, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR 455) about disclosure reporting." Please clarify the MCO's responsibility with respect to non-contracted providers.	The MCO's responsibility is the same for both contracted and non-contracted providers.

95.	IV.O.1.j Program Integrity - General Requirements	133	The staffing ratio required under the Program Integrity section is one (1) investigator for every 50,000 or fewer members; however the Staffing Requirements section (IV.D.3.i,p.51) states a ratio of one investigator for every 100,000 members or less. Please clarify which requirement the MCO should abide by.	The MCO is required to comply with the ratio requirement of one (1) investigator for every 50,000 or fewer members as stated in Section IV.O.1.j. Section IV.D.3.i is hereby amended as follows "The MCO must have a minimum of one investigator for every 50,000 members or less."
96.	IV.O.3.a.ii. Program Integrity - Prohibited Affiliations	134-135	The cited section identifies those parties with whom an MCO may not knowingly have a relationship. The listed parties include the following: "An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of: a) A director, officer, or partner of the MCO. b) A person with beneficial ownership of 5% or more of MCO equity. c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with the State. " Please confirm that a company, such as a parent or affiliate company, would not	A parent or affiliate company is not considered a person with respect to this requirement.

			be considered a “person” with respect to this requirement.	
97.	IV.O.15.b Program Integrity - Investigative Collaboration	140	Please clarify whether the ten year timeframe for investigation is limited only to that timeframe in which the MCO had a relationship with the applicable member or provider.	The ten year timeframe applies to the MCO and a parent or affiliate company's relationships with a provider.
98.	IV.P.2.e MCO Reimbursement - Capitation Rate Determination Process	142	Categories of eligibility include those individuals receiving LTSS, both institutional and home and community-based services. Please clarify those covered services for these categories of eligibility that the MCO will be responsible for.	The services covered for these individuals are outlined on page 54 of the RFP, Section IV.E.8. This includes physical health services, behavioral health services, and pharmacy services, and excludes NEMT non-ambulance, dental services, and long term services and supports.
99.	IV.P.5.g., IV.P.5.i MCO Reimbursement	144	"The supplemental payment for deliveries is intended to reimburse the MCO for five (5) months of prenatal care, the delivery, and two (2) months of post-partum care.” “The MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.”	Yes, the supplemental payment will be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO. The supplemental payment is initiated by the MCO sending maternity care information in the Maternity Care Payment file. In the absence of a hospital inpatient stay the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.

			Will the supplemental payment be issued to the MCO in which the mother is enrolled at time of delivery if maternity care (prenatal and/or post-partum care) is rendered by another MCO? Does the encounter data for maternity care and the delivery need to be submitted by the same MCO in order to trigger the supplemental delivery payment?	
100.	IV.P.12.a MCO Reimbursement - Administrative Cap	148	"Per Neb. Rev. Stat. §71-831, 68-908, and 71-801 (2012), the MCO's administrative spending must not exceed 7%, except up to an additional 3% is allowed, if the additional amount is for the purpose of quality improvement and approved by MLTC." Please describe the MLTC approval process to determine whether certain administrative spending would qualify for "the purpose of quality improvement." Will there be a mechanism for this approval prior to submission of the RFP response? Additionally, the statutes cited above appear to refer to behavioral health services	Attachment 5 is hereby amended to include a Quality Administrative Expenses proposal for review and approval of quality activities for consideration in the 3% admin cap. The proposal is due 120 days prior to contract start date. The provision related to the Administrative Cap applies to all administrative expenditure.

			only. Does this provision related to the Administrative Cap apply to all administrative expenditures or just those specifically related to behavioral health services?	
101.	IV.P.12.e MCO Reimbursement - Administrative Cap	148	"Hold-back funds, both earned and forfeited, are factored into the administrative cap calculation." Does this include both the holdback associated with the MLTC Quality Performance Program (1.5% of the aggregate of all income and revenue) as well as the State Performance Penalties (0.25% of the aggregate of all income and revenue)?	See response to Question #33.
102.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Please confirm that the 30% and 50% of the provider network measures that relate to Value-Based Contracting, refer to the number of contracts or providers and not the number of members.	30% and 50% of the provider network refers to the number of providers.
103.	IV.Q.6.b Provider Reimbursement - Value Based Contracting	150	Does this include all provider types? How is the denominator determined? Is it practitioners only or does it also include facilities?	The denominator includes all providers within the MCO's network.
104.	IV.Q.10 Provider Reimbursement -	152	Medicare cost reports are not prepared until well after the CAH's fiscal year end. Is the	MCOs are to use the cost report provided by DHHS Financial Services for cost settlement activities with CAHs.

	Critical Access Hospital Contracting and Reimbursement		MCO to use a mechanism other than the Medicare cost report? If the Medicare cost report is to be used, is the MCO to use the “as-filed” cost report, or the cost report that was audited and settled by CMS?	
105.	IV. Q.17.c Provider Reimbursement - Maximum Allowable Cost Program	153	Would the MCO be able to provide the information behind a secured connection on the MCO's website?	See response to Question #74.
106.	IV.R.8.d.iv Systems and Technical Requirements - Provider Enrollment	157	Please specify what, beyond including a provider's NPI, what specific "NPI requirements" must be included in the provider enrollment system?	Any NPI requirement that is transmitted to the MCO through State interface file must be included in the provider enrollment system.
107.	IV.S.15.f.i Third-Party Liability	176	Does the 365 day timeframe apply to overpayment recoveries for any reason, or only circumstances where TPL recoveries have not been successful?	The MCO is expected to recover overpayments for any reason within 365 days. If the MCO is unsuccessful in recovery after 365 days, MLTC may pursue recovery.
108.	IV.T.3.b Reporting and Deliverables - Information Related to Business Transactions	177	Please clarify what will constitute "full and complete information" that must be provided regarding ownership of subcontractors. Also, what would MLTC consider a "significant business transaction" between the MCO and a wholly owned supplier?	Full and complete information includes all information necessary to address disclosure requirements in IV.T.3.b.i and IV.T.3.b.ii. "Significant business transaction" is specified in IV.T.3.c.

109.	V.A.2.j Proposal Submission - Corporate Overview	198	Is there a threshold (percentage of revenue or dollar amount) that would apply to Subcontractors that should be identified for this requirement? Is this requirement limited to Subcontracts for certain services (e.g. care management or coordination services)? Does this requirement exclude providers contracted for participation in the Managed Care Organization's provider network?	Providers are not considered subcontractors. Bidders should address subcontracting in Attachment 19 on Questions #56 and #57.
110.	Attachment 6: Reporting Requirements Provider Grievances	Attachment 6, p.2 of 10	Please clarify that the Provider Grievance System (Appeals and State Fair Hearing) are intended to report the provider filing on the member's behalf only.	The Provider Grievance System reports for Appeals and State Fair Hearings are meant to summarize provider-related appeals and provider-related state fair hearings. Providers acting on behalf of members in appeals and state fair hearing proceedings would be summarized in the Member Grievance System reports.
111.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	What are the dollar values of the transplant costs included in the Medical PMPMs shown in Attachment 11 – Rates?	The dollar value of the transplant costs in the medical PMPMs is $5.5 million in Rating Region 1 and $1.6 million in Rating Region 2.
112.	Attachment 11 – Rates	Attachment 11, Page 1 of 1	Please show the components of the Maternity and Katie Beckett non-medical loads separately by Admin, Quality Improvement, Performance Guarantee and Profit/Risk/Contingency as	See Attachment 21: "Non-Medical Load Assumptions" which identifies the Non-Medical Load components used at each end of the rate range by COA and region.

			shown for the composites in the Optumas Bidders' Conference Rate Presentation page 15.	
113.	Attachment 12 - Historical Transplant Cost Distribution Data	Attachment 12, Page 1 of 1	Are the transplant costs shown in Attachment 12 for the four-year period SFY2010-SFY2014 in total? If so, what are the costs by each SFY? What are the costs by Region?	Transplant costs in Attachment 12 are for the five year period SFY10 to SFY14. Transplant costs by year are: $5.4 million in FY10, $4.5 million in FY11, $7.1 million in FY12, $7.6 million in FY13, and $6.0 million in FY14. Costs by Region are not available.
114.	Attachment 13 Neb. Rev. Stat. 71-831	Attachment 13, p.1 of 1	Please verify that the restrictions contained in this statue apply specifically to behavioral health services and not to the broader scope of services to be provided by the Medicaid Managed Care Organization.	As the statute is currently written, the provisions of the statute would apply to the full scope of services.
115.	Attachment 13 Neb. Rev. Stat. 71-832	Attachment 13, p.1 of 1	"(2) Provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners, under the contract;" Please verify that the	This restriction is limited to only those revenues derived from this specific contract. The State will determine the compliance review process during readiness review.

			restrictions on profits and losses applies to the contractor and related parties, including parent and subsidy (sic) companies. Please clarify that this restriction is limited to only those revenues derived from this specific contract. How will the State measure or validate compliance with this requirement?	
116.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR requirement be calculated as an aggregate of Regions 1 and 2 or separately for each region?	The 85% Minimum MLR requirement will be calculated as an aggregate of Regions 1 and 2.
117.	Attachment 15 - Medical Loss Ratio	Attachment 15, Pages 1 and 2 of 2	Will the 85% Minimum MLR be aggregated over all categories of aid or separated for LTSS versus Non-LTSS subgroups?	The 85% Minimum MLR requirement will be calculated as an aggregate of all categories of aid.
118.	General - Capitation Rate Development	N/A	Please provide an example for the calculations flow from base data to final capitation rates, including how adjustments and trends are applied.	All adjustments applied to the base data to develop the final capitation rates have been provided to the bidders as part of the pre-proposal conference presentation. See Attachment 20: “COA-level Rate Development” for the step-by-step application of these adjustment values to the base data. The Effective Trend Days shown in this document represent the effective number of days needed to trend the base data to the contract period given the different base periods for Physical Health, Behavioral Health, and Behavioral Health Foster Care. Trend is applied at a COS-level, with each COS being trended for the appropriate number of days.
119.	Attachment 19	Attachment	For those questions with	Attachments will not count toward the questions' page limits as

	Proposal Statements and Questions	19	page limits, would attachment(s) count towards the question's page limit? Is there a page limit on attachments?	there is not page limits on attachments.
120.	Attachment 19 Proposal Statements and Questions	Attachment 19 p.2 of 21	Please confirm that the correct RFP Section Reference for Question#10 should read "IV.C Business Requirements" (and not IV.B).	The RFP Section Reference for Question #10 is hereby amended as follows: "IV.C Business Requirements."
121.	Attachment 19 Proposal Statements and Questions	Attachment 19 Page 1 of 21	Please confirm that the correct reference for question #5 is Section III. F., not III.G.	The RFP Section Reference for Question #5 is correct as listed. The RFP Section Reference for Question #4 in Attachment 19 is hereby amended as follows: "Section III.F Insurance Requirements".
122.	5151Z1 Evaluation Criteria Attachment	Evaluation Criteria p.2	Please verify that only the “top-scoring bidders” may be invited for oral presentations at the State’s discretion as stated in Section II.G on page 3. If the State opts to proceed with oral presentations, will all “top-scoring bidders” be invited for oral presentations in order to allow for an equitable opportunity among “top-scoring bidders” to earn the 150 points identified in the Evaluation Criteria Attachment?	The State reserves the right to select only the top scoring bidders for oral presentations.
123.	Proposal Statement and Questions	Attachment 19, page 4	Is the work plan requested in this question part of the larger transition/implementation plan, or a stand alone?	The work plan requested should stand alone as a plan for implementation of Pharmacy Services as described in the RFP. It may also be a component of a bidder's larger transition/implementation plan.

124.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of information that will be available on the member website be counted in the 6-page limit?	Examples of information that will be available on the member website will not be counted in the page limit.
125.	Proposal Statement and Questions	Attachment 19, page 5	Will the examples of member education be counted in the 10-page limit?	Examples of member education will not be counted in the page limit.
126.	Proposal Statement and Questions	Attachment 19, page 5	Will the flowchart be counted in the page limit? If not, please consider extending the page limit as three pages to provide a "comprehensive written description" and flow chart are not likely to be sufficient.	The flowchart will not be counted in the page limit.
127.	Proposal Statement and Questions	Attachment 19, page 11	Please confirm that the page limit excludes the proposed health risk assessment template.	The proposed health risk assessment template will not counted in the page limit.
128.	Proposal Statement and Questions	Attachment 19, page 12	Will the proposed QAPI work plan be included in the 10-page limit?	The proposed QAPI work plan will not be counted in the page limit.
129.	Proposal Statement and Questions	Attachment 19, pg 17	How does the state define "30% of its provider network"? 30% of providers? 30% of contracts? 30% of spend? Other?	See response to Question #102.
130.		Attachment 19	Attachment 19 does not contain any questions related	Confirmed.

			to section IV.G Member Marketing of the RFP (pages 82-87). Please confirm that this correct.	
131.	III.	Page 7	Please confirm that rates are applicable for the initial contract term of six months (1/1/17-6/30/17).	The initial contract term will be 12 months, 1/1/17 – 12/31/17. This is consistent with the rates in Attachment 11, which represent a Calendar Year 2017 contract period.
132.	III.F.3.	Page 10	Please provide details regarding the underlying medical claims so that we may comply with III.F.3.d. For example, please provide member-specific annual spend levels for the over-certain attachment points (e.g., 50K, 100K, 150K, 200K).	The details requested in this question are not available.
133.	III.EE	Page 19	The performance bond amount of $50M appears to be for entire program. How will the amount applicable to each bidder be determined?	Each contract awarded from this RFP will require a $50 Million performance bond. See the response to Question #11.
134.	IV.A.1.f.iii	Page 31	Who is the current enrollment broker?	The current enrollment broker is The Medicaid Enrollment Center
135.	IV.A.1.g.ii.	Page 31	This states that the “Inclusion of pharmacy service in the core benefit package and the MCO capitation rate at a date to be determined by MLTC”; however, Attachments 10A-10D appears to have pharmacy included. Do the	Rates provided include pharmacy. See response to Question #61.

			rates provided include pharmacy? What is the timeline for the pharmacy inclusion?	
136.	IV.B.4.b.ii.and iii	Page 35	This section states that the MCO will not be responsible for services rendered to a member prior to the date of enrollment; however, IV.B.4.h. states that the MCO is responsible for member care on the first day of the month in which eligibility was determined. Will there be a limited amount of time that a member's eligibility will be retro'ed onto managed care?	See response to Question #19.
137.	IV.B.4.c	Page 35	Does the MCO have sole authority to manage and report member status changes or will members still be reporting changes directly to ACCESSNebraska? When contradictory information is reported, what information will be used?	The MCO is responsible for providing information to ACCESSNebraska as set forth in Section IV.B.4.c.i of the RFP. The member is responsible for contacting ACCESSNebraska to report all status changes. The ACCESSNebraska will validate the information when reported.
138.	IV.B.5.d & e	Page 36	Item 5.d outlines conditions for PCP auto-assignments (d.i - d.iii). In 5.e the requirement notes that two situations require the MCO to reach out to the member and ask him/her to make an alternate PCP selection,	The first sentence of Section IV.B.5.e is hereby amended as follows: "If either of the two (2) situations set forth in provision IV.B.5.d.ii or IV.B.5.d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection."

			referring to d.i and d.ii; however, the conditions would suggest that this should actually refer to d.ii and d.iii, since those conditions concern members who have made a PCP selection, whereas d.i concerns members who have not made a selection. Please confirm that requirement 5.e should read: "If either of the two (2) situations set forth in provision d.ii or d.iii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection..."	
139.	IV.E.11.b.vi.	Page 59	Will the state make available and be ready to accept new procedure codes and have rates established so that the MCOs can meet this standard?	The State will accept all valid procedure codes and establish rates so that the MCO can meet this standard.
140.	IV.E.11.b.ix.a	Page 59	Does this requirement intend that all appeal rights would need to be available / exercised within one business day?	Member appeal rights are provided in Section IV.H.
141.	IV.E.12.c	Page 61	In instances in which the MCO must authorize a service not included in the State Plan, would the state be	The State's MMIS accepts any valid procedure codes. Any criteria not previously posted for these determinations must be developed and submitted to MLTC for review and approval in accordance with Section IV.N.4.c. of the RFP.

			able to accept all procedure codes not currently utilized and accept all associated rates? Additionally, would the MCO be supported in utilizing Medical Necessity Criteria not previously posted for these determinations?	
142.	IV.E.28.a.	Page 66	Are NEMT included in the contractor's rates? Are the contractors responsible for NEMT?	See response to Question #82.
143.	IV.E.29.d	Page 67	Please confirm that services rendered in school settings would be excluded.	Per Section IV.E.29, school-based services are excluded.
144.	IV.F.4.d and IV.F.13.b.i	Page 70 and page 80	The requirement for distributing new member materials appears to be within 30 calendar days of enrollment (page 70). However, there is further instruction (page 80) to send welcome packets to new members within 10 business days of receiving the new member file. Please clarify the difference in these requirements.	The first sentence of Section IV.4.d is hereby amended as follows: "The MCO must distribute member materials to each new member within ten (10) calendar days of enrollment." Welcome packets are required to be distributed within ten (10) business days of receiving the member file. Please see Section IV.F.13.b for included requirements. New member materials may be other materials not specified in Section IV.F.13.b and must be distributed within 30 calendar days of enrollment.
145.	IV.H.6.i.b.iii	Pg. 92	Assuming all services will be ordered by an authorized provider, is the intention of this language that a continuation of benefits is	See Section IV.H.6.a. for when the MCO must continue a member's benefits.

			required for all appeals?	
146.	IV.I.2.a	Pg. 94	Does this requirement intend to state that the MCO cannot pay providers of different licensing status different rates? Additionally, does this requirement prevent an MCO from restricting the services eligible for reimbursement for licensed providers when service delivery is within the scope of the practitioner's license?	This requirement is not intended to prevent an MCO from negotiating payment rates based on license type. The MCO may not restrict the services eligible for licensed providers when service delivery is within the scope of the practitioner's license.
147.	IV.J.4.c.ii	Pg. 106	Does this requirement mandate that all services must have online authorization request capability?	Online authorization capability is required for the services the MCO identifies as requiring prior authorization.
148.	IV.L.5.f	Pg. 116	As members are typically not eligible for Medicaid care during a State hospital stay (n accordance with IMD regulation), does this language mandate MCOs to coordinate care for members not eligible for managed care or is the intention to enroll members into managed care while still in State hospitals? Does this expectation extend to transition plans for youth transitioning out of State-run PRTF facilities as well?	Section IV.L.5.f requires the MCO to develop, implement, and evaluate written policies and process consistent with existing State policies and procedures regarding continuity of care. This includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. The expectation for care coordination and transition planning does include youth transitioning out of a State-run PRTF.

149.	IV.N.6.b	Pg. 129	Does this requirement mandate the use of specific set of Medical Necessity Criteria (clinical guidelines) for continued Inpatient stay specifically?	MLTC is not mandating the use of a specific set of Medical Necessity Criteria.
150.	IV.O.1.e.	Page 133	This section requires the MCO to report any suspicion of fraud to NMPI immediately. Section IV. O.12.b. (Page 138) requires reporting of tips and referrals a minimum of every two weeks. Can you clarify the reporting expectation regarding early suspicion of possible fraud?	The MCO is required to immediately report suspicion of fraud via email and on a template developed by MLTC.
151.	IV.O.1.j	Page 133	Section IV.O.1.j requires a minimum of one investigator for every 50,000 or fewer members. Section IV.D.3.i (Page 51) requires one investigator for every 100,000 members. Please clarify the staffing requirement for investigators.	See response to Question #95.
152.	IV.O.6.e	Page 136	If MFPAU chooses to intervene in an MCO hearing or review of sanctions against a provider, will the MCO be notified of this intervention in writing?	Yes, MFPAU will notify the MCO in writing of intention to intervene.
153.	IV.O.6.e	Page 136	Will MLTC consider placing a reasonable limit on the	MFPAU has the right to intervene in proceeding and suspend until the MFPAU's investigation is complete.

			amount of time the MCO may be required to suspend proceedings, particularly as provider appeals may need to be processed according to specific timeframes to maintain required accreditation?	
154.	IV.O.11.b	Page 139	Will MLTC provide the MCO with any available data regarding recipients' dates of death or dates of incarceration to facilitate the required quarterly audit?	This information will be provided via the member enrollment files.
155.	IV.O.15.b	Page 140	Is the intent of this section that the MCO will investigate cases of suspected fraud for periods of time prior to the current contract?	See response to Question #97.
156.	IV.O.17	Page 141	Section IV.O.17 requires consultation with NMPI and MFPAU prior to recoupment in "these circumstances". Section IV.O.1.f (Page 133) requires the MCO to pursue "all recovery of payments identified as FWA" and other sections require the pursuit of overpayments when TPL is identified. Please provide a definition of the specific circumstances under which NMPI/NMFPAU consultation is required prior to recouping	The first sentence of Section IV.O.17 is hereby amended as follows: "If the MCO thinks that it is appropriate to initiate a recoupment or withholding action against a provider, the MCO must consult with both NMPI and MFPAU to ensure that such action is permissible."

			identified overpayments.	
157.	IV.P.2	Page 142	Please provide enough detail to determine how rates are figured, including each step of the process, from determining base to final rate.	See response the Question #48.
158.	IV.P.2.e.xx.	Page 143	What is the rationale for coordinated care savings and amount of adjustment applied to the rates?	The only program change similar to a coordinated care saving is the service delivery adjustment applied to the dual population. Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of care duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to this dual population is a reduction of 5.4%. Outside of the dual population, there are no assumed savings due to coordinated care used in creating rate ranges.
159.	IV.P.2.k.	Page 143	When will the narrative on the capitation rate be available?	See Attachment 22: "Heritage Health Rate Development Narrative", for an overview of the rate setting methodology.
160.	IV.P.5	Page 144	Can you confirm that the maternity supplemental payments made to the MCO will be counted as Qualifying revenue for both the risk corridor calculation and the administrative cap calculation?	Confirmed.
161.	IV.P.5/ Attachment 10	RFP Page 144, Attachment 10 maternity cohort	Can you provide any detail on the rate for the maternity supplemental payments? Also, can you provide any databook information on the number of qualifying births in	The rate for the maternity supplemental payments is shown as the "Maternity" category of aid on the rate exhibits. Similarly, the "member months" for this aid category represent the qualifying deliveries.

			the State?	
162.	IV.P.12	Page 147	Please provide claims volume for the most recent two fiscal years. Identify electronic receipt versus paper.	The State cannot respond to this request without additional information. Submit question with specific claim type information in order to respond to this question. Please submit further detail during the second round of questions.
163.	IV.P.12	Page 147	Please provide call volume, delineated between business hours versus after hours for the two most recent fiscal years.	The State needs additional information on the type of call volume. Please submit further detail during the second round of questions.
164.	IV.P.12	Page 147	What services need prior authorization and what are the volumes related to those services for the two most recent fiscal years.	The State needs additional information on the prior authoirizations for fee for service. Please submit further detail during the second round of questions.
165.	IV.P.12	Page 147	Since the administrative cap calculation includes the hold-back, will it just be calculated as "gross" revenue in each month, or will the hold-back only be included when settled a the end of each fiscal year? If it's only included at the end of the fiscal year, for which fiscal year will it appear in the calculation?	The capitation rates have been developed such that the administrative cap calculation is gross of the 1.5% hold-back, so that to the extent the MCO earns back the entire 1.5% hold-back at the end of the fiscal year, the administrative load provided to the MCO will remain under the required cap. It would be calculated in the fiscal year in which the hold-back occurs.
166.	IV.Q.13	Page 154	This section states that the MCO must reimburse a member for any payments made by the member, for services rendered during a period of retro eligibility. Would this apply to situations	All services that would have been covered by the Medicaid FFS program must be covered by the MCO, retroactive to eligibility. To clarify the process for member reimbursement, IV.Q.13 is hereby amended as follows: "The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The MCO must reimburse a provider and that provider must

			in which services previously rendered are determined to not be medically necessary?	reimburse a member for payments already made by a member for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a MCO will match the Medicaid eligibility date."
167.	IV.R.1.c	Page 154	Approximately how many MLTC staff will require access to the MCO's systems? Will all staff require the same type of access or will individual staff access vary based on the role of the individual user?	Currently, the State does not have access to the MCOs systems. This will be determined during the readiness review process with awarded MCOs. Access wil vary based on the individual user.
168.	IV.S.3.ii	Page 164	Does this language only extend to the MCOs contracted by the State of Nebraska or would it extend to timely filing processes for other primary payers?	This language would extend to timely filing process for other primary payers.
169.	IV. S.15.b.ii	Page 174	Please clarify if the MCO may choose to pay and chase for the three listed categories of claims or if the MCO is mandated to pay and chase rather than cost avoid in these cases.	The MCO may choose to pay and chase for the three listed categories of claims.
170.	IV. S.15.b.ii.c	Page 175	Will MLTC provide an indicator to the MCO identifying Title IV-D child support individuals to assist in appropriate COB efforts?	Yes, this indicator will be provided via the enrollment files.
171.	A.2.h	Page 197	The instructions note that the State will use no more than three narrative project	See the response to Question #44.

			descriptions during proposal evaluation. Are we limited to describing three similar projects? If not, how will the State select the three to consider in the evaluation?	
172.	V. Proposal Instructions	Pages 196-198	There are several questions where additional information is specifically requested to be attached (e.g., copy of COA, work plans, sample materials). Is it permissible to include attachments that are not specifically requested?	Attachments that are not specifically requested may not be considered in the evaluation process.
173.	A.2.h	Page 197	Can bidders include experience from affiliate organizations/sister companies?	Yes.
174.	A.2.h	Page 197	Please clarify what "budget" information the state would like us to include (e.g., contract value)?	Per Section V.A.2.h.i.e, "Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget." The budget as indicated above refers to the project budget verus the actual budget.
175.	N/A	Page 1	The Key Staff Resumes item from Attachment 5 requests that resumes be included in the proposal only for key personnel. However, Item	The State would prefer resumes for key personnel.

			A.2.i Summary of Bidder's Proposed Personnel/Management Approach on page 198 of the RFP requests that resumes be provided for all proposed personnel. Which does the state prefer?	
176.			What are the metric definitions associated with the measures outlined in this attachment?	All measures included in Attachment 7 are nationally recognized quality measures. More information can be found on the Adult Core Set Measures and Child Core Set Measures by visiting the CMS website at www.cms.gov. HEDIS measures can be found on the NCQA website at www.ncqa.org.
177.			For the Rx factors of 6.5% and 6.7%, could the underlying assumptions used be provided? i.e. Inflation, utilization, drug-mix, off-patent, new medications etc.	The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, this information will be available.
178.	Item 4	Page 1	Please define QI admin expenses allowed with the additional 3% admin cap and explain how those expenses differ from the expenses allowed in the MLR calculation	The Glossary of Terms is amended to add: **Quality Improvement (QI) Expenses**: These are expenses for the direct interaction of the insurer, providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined below. This category can include costs for associated activities such as: **1.** Effective case management, Care coordination, and Chronic Disease Management, including: **a.** Patient centered intervention such as: **i.** Making/verifying appointments; **ii.** Medication and care compliance initiatives; **iii.** Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation

				center); **iv.** Programs to support shared decision making with patients, their families and the patient's representatives; **v.** Reminding insured of provider appointment, lab tests or other appropriate contact with specific providers; **vi.** Incorporating feedback from the insured to effectively monitor compliance; **vii.** Providing coaching or other support to encourage compliance with evidence based medicine; **viii.** Activities to identify and encourage evidence based medicine; **ix.** Activities to prevent avoidable hospital admissions; **x.** Education and participation in self-management programs; and **xi.** Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance. **b.** Improve patient safety; **c.** Wellness and health promotion activities; **d.** Health Information Technology (HIT) expenses related to Quality Improvement Activities: **i.** Data extraction, analysis and transmission in support of the activities described above; and **ii.** Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care. **2.** The following items are broadly excluded as not meeting the definitions above:

				a. All retrospective and concurrent Utilization Review; **b.** Fraud Prevention activities; **c.** The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network; **d.** Provider Credentialing; **e.** Marketing expenses; **f.** All Accreditation Fees; **g.** Costs associated with establishing or maintaining a claims adjudication system; **h.** Costs associated with calculating and administering individual enrollee or employee incentives; and **i.** Any function or activity not expressly listed as approved.
179.	Item 4	Page 1	Can you confirm that if QI expenses are allowed for the numerator MLR calculations, they would then be classified as medical costs and not count towards the 10% administration cap.	The QI expenses allowed for the numerator would count towards the 10% administrative cap per state statute.
180.	Bidders Conference Rate Presentation	All pages	Is cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center included in this program? If so, why is it not included in the rate development?	Yes, the cost settlement for PRTF payments to Hastings Regional Center and Lincoln Regional Center is included in the developed rates. It is included as part of the “Other Policy Changes” in the NE Heritage Health Bidder's Conference Rate Presentation (Optumas) on slide 11 of 20.
181.	Bidders Conference Rate Presentation		Please detail what the service delivery adjustments are and how they were created	Please see the response to Question #158.

182.	Bidders Conference Rate Presentation		Please detail the immediate enrollment policy adjustment. How was this adjustment developed?	The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the managed care program after the policy was implemented.
183.	Bidders Conference Rate Presentation		Please detail all other policy changes (APR-DRG, FQHC APM, BH Provider Increase) – how were these developed?	APR DRG: On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. The State's actuaries then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO. The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the

				impact is close to budget neutral in aggregate but does show increases and decreases by rate cell. FQHC APM: Effective 1/1/2016 the State will begin paying Federally Qualified Health Centers (FQHCs) a new Alternative Payment Methodology (APM) rate. To account for the impact this reimbursement change will have on the Heritage Health capitation rates, the State's actuaries identified all FQHC utilization in the base data and priced it at the new APM rate. The pricing was done separately for the FY14 and FY15 base data sets, and the resulting impact was blended together at a 50/50 rate consistent with the overall rate development. BH Provider Increase: The behavioral health provider increase is a legislatively-mandated fee schedule change applicable to behavioral health providers. Recently this change has been a 2.25% increase to behavioral health provider reimbursement, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the State's actuaries assumed the 2.25% annual increase will remain consistent. The provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015 and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied.
184.	Bidders Conference Rate Presentation		Were the same trends by Category of service applied to each category of aid? Were unit cost and utilization trends	Attachment 23:"COS and COA Trends" contains the trends by category of service and major category of aid. The trend model used to develop these figures is not available. The development process consisted of reviewing FY13, FY14, and FY15 data by

			created separately? Please provide the trend analysis to support the chosen trend numbers.	month, category of service, and major category of aid. Data was controlled for membership mix by rolling up sub-categories of aid on the most recent month's membership mix to create major categories of aid. Data was also controlled for known policy changes by increasing data prior to the policy change to be consistent with the value after the policy change became effective. Nebraska data was the primary source for trend development, but the State's actuary's national and regional experience was also used to inform trend values. Additional details, such as utilization trend and unit cost trend, will be provided when rates are updated in the spring.
185.	Bidders Conference Rate Presentation		Please provide the detail behind the UNMC PMPM adjustment.	The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then passed through from the MCOs to UNMC. To develop this rate pass-through the State's actuaries receive a list of UNMC Provider IDs from the State as well as the current managed care entities. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.
186.	Bidders Conference Rate Presentation		Please provide the development of the 2.9% NML for Katie Beckett and	See Response to Question #112.

			Maternity categories. How does this account for the quality initiatives and profit?	
187.	Bidders Conference Rate Presentation		Please provide the build of NMT for each rate cell.	Effective 7/1/2015, the Non-Emergency Transportation-Ambulance service will be provided as part of the managed care contract. This service was not a required benefit under the managed care contract during the duration of the base data period (SFY14-15). While very low utilization was included within some of the base data, historical Nebraska FFS data (SFY08-10) was trended to the contract period and used to supplement the base data. The PMPM added in by cohort and Rating Region for NEMT-Ambulance services can be found in Attachment 24: "NEMT-Ambulance Rates."
188.	Bidders Conference Rate Presentation		Will the retro adjustment be included in the revised rate that will be provided in the spring?	Yes.
189.	I.A.Schedule of Events	1	Given the short time to review the RFP in advance of the first Pre-Proposal Conference, we believe a second bidders' conference would be beneficial and most efficient for all. This will ensure that all bidders have an opportunity to understand the proposal in its entirety and result in the best possible bidding process. Please confirm the State will hold the second conference on 11/19.	See Addendum 2-Revised Schedule of Events.
190.	I.A.Schedule of Events	1	It is our understanding that the Attachment 11 rates are not final. Given the	See section IV.P.2 for a detailed description of the Capitation Rate Determination Process.

			anticipated large rate adjustments that will be made in the Spring, how will the winning MCOs be involved in determining the final rates for 1/1/17-6/30/17?	
191.	III QQ. Prices	24	Please confirm that bidding MCOs will not be required to submit anything, besides QQ, as part of their acceptance of the rates under the contract.	Confirmed. No cost proposal is required.
192.	IV. A.1 b. Program Description	30	This section states: "Nebraska Medicaid currently provides health care coverage for approximately 239,000 individuals each month at an annual cost of approximately $1.8 billion." However, Attachment 11 has an average of 228,000 eligibles that produce $1.1 billion in revenue including the UNMC supplemental payment. Please describe the difference. Are the rates presented in Attachment 11 capturing all of the expenses?	The difference is caused by populations and services excluded from Heritage Health. The rates presented in Attachment 11 are capturing expenses for the included populations and services.
193.	IV. A.1 d. Program Description	30	Please describe all current and anticipated CMS waivers under which this program will operate.	The current managed care program and Heritage Health will operate under State Plan and 1915(b) Waiver authority.
194.	IV.A.11. Excluded	32	This section states that the	The details requested in this question are not available. The members with a share of cost will be contained in the LTSS data

	Populations		following members are excluded: ""Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost (SOC) obligation to a nursing facility or for HCBS Waiver services."" Therefore, please confirm the following about the members with SOC that are the MCOs' responsibility: a) Please provide a separate databook/amounts for the members who will be the MCOs' responsibility and have SOC by fiscal year, region, and rate cell. b) Please describe all administrative obligations of MCOs with respect to the collection of this share of cost. c) Please describe the manner in which rates are developed with regard to share of cost: is the rate developed in total, with the share of cost flowing through the state to the MCOs? Is the rate developed net of the share of cost obligation? Is	book, but the State's actuaries cannot presently isolate only those members with a share of cost obligation. The share of cost payments are paid to nursing facilities or HCBS providers that are outside of the benefits package of Heritage Health. Rates are developed net of the members' cost share obligation.

			there a settlement of some kind?"	
195.	IV.B.2.f. Member Enrollment/ Assignment	33	"Please clarify the MCOs' responsibility with regards to the retroactive time period: a) Please provide the membership, expenses, and utilization (by region, category of aid and category of service) associated for the total retroactive time period that the MCOs will be responsible for covering. b) Please provide the average length of the retroactive period by category of aid and region. c) Please describe the differences between the retroactive time period and the immediate enrollment. d) Is there a maximum retroactive period that MCOs would be responsible for? e) Is there any limitation on the types of services MCOs would be responsible for retroactive from enrollment date to retroactive eligibility date?"	Please see the response to Question #19 regarding a MCO's responsibility for retroactive time periods. Data analysis will be conducted to determine the cost of retroactive time periods compared to regular enrollment time periods. As discussed during the first pre-proposal conference and stated on the "NE Heritage Health Bidder's Conference Rate Presentation (Optumas)" retroactive time period analyses have not been conducted yet. The State's actuary will conduct these analyses when developing actuarially sound rates in early 2016. At that time, splits in the data as requested in parts a), b), and c) will be available.
196.	IV.B.2.f. Member Enrollment/	33	Please confirm that any retroactive liability will only go	See response to Question #19.

	Assignment		back to 1/1/17. For example, if a health plan is assigned a member on 4/1/17 whose eligibility date is 7/1/16, is the health responsible for claims incurred back to 7/1/16 or 1/1/17?	
197.	IV.B.2.f. Member Enrollment/ Assignment	33	In Optumas' presentation during the Pre-Proposal Conference, it was stated that there is limited credibility for the ABAD members under 1, such that it would be difficult to develop an actuarially sound rate cell for only these members. It was also stated during that meeting that an adjustment would be developed at a later date to capture any additional costs for retroactivity. We feel that the retroactive requirement could be particularly volatile for this population, and therefore, the retroactive adjustment would likely be difficult to calculate and have a significant impact on plan financial stability. Please consider covering retroactive costs for this population under fee for service, rather than making it the responsibility of winning MCOs	During rate development the contracted actuary separates AABD members under 1 from other AABD members. This allows for analysis of the population's spend and credibility. The contracted actuary will continue a similar practice with regards to retroactive enrollment expenses for AABD infants. While it is not anticipated that this population will become credible enough to stand alone for rate setting. The contracted actuary will continue to analyze it and develop rates to mitigate this population's volatility as much as possible.

198.	IV.3. Member Enrollment/ Assignment	34	Please confirm that there are no firm enrollment floors or caps to prevent certain MCOs from having more than or less than a certain percentage of total enrollment.	See Section IV.B.3. regarding the auto-assignment algorithm.
199.	IV.E.7. Telehealth and Telemonitoring Services	54	Please describe where the costs for these services are incorporated into the base data. Also provide the utilization and unit cost assumptions (by region and rate cell) for this service embedded in the capitation rates.	Telehealth services are currently submitted using a procedure code modifier. The claim associated with telehealth services is grouped into service categories based on different service type indicators, such as provider type, place of service, etc. The telehealth services predominantly fall into professional service categories including PCP, Specialist, and Other Practitioner. The contracted actuary does not have summaries for detailed line telehealth services available.
200.	IV.E.22. Medical Services for Special Populations	65	"Please provide the following related to the SHCN population: a) a separate data book (including membership, expenses and utilization by region, rate cell, and category of service) for the SHCN population. b) Please explain why the SHCN population is not included as a separate category of aid c) Please provide the process through which new MCOs (without historical claims data) are expected to identify	This level of detail is not available. The SHCN population is too small and volatile to maintain rating credibility as a separate category of aid. The State's actuary will continue reviewing this population to determine if it becomes credible. Historical pharmacy claims data will be provided.

			these members."	
201.	IV.I.7. Patient-Centeredness/Patient-Centered Medical Homes	97	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions associated with these requirement in the development of the capitation rates.	Costs for services provided under a PCMH system are not itemized separately from services provided outside of a PCMH system. The non-medical loading applied to the rate is sufficient to fund health plan administrative efforts necessary to support PCMH programs.
202.	IV. I. 8. c. Pharmacy Network	98	For purposes of the provisions related to specialty pharmacies and specialty drugs, please provide a listing of NDC codes that are considered to be specialty drugs, as well as a description of the process of updating this list.	See response to Question #75.
203.	IV.L.2. Health-Risk Screening/Assessment	112	Please describe where the costs for these services are incorporated into the base data. Please also provide the assumptions built into the rates for this requirement.	The costs are considered in the admin portion of the capitation rates as they are not direct services.
204.	IV. P.2 Capitation Rate Determination Process	142	This section states that capitation rates will be in effect for the initial six month contract period beginning with the program start date. Later, it is stated that MLTC and its actuary will develop actuarially sound capitation rates. Please confirm that the	Section IV.P.2.c is amended to read: “Capitation rates will be in effect for the initial twelve (12) month contract period beginning at the contractor start date.”

			capitation rates shown in attachment 11 will be in effect from 1/1/2017 through 6/30/2017.	
205.	IV. P.2 Capitation Rate Determination Process	142	Please confirm whether the next set of capitation rates will be developed for the period 7/1/2017 through 6/30/2018 or through 12/31/2017.	The next set of capitation rates will be effective for Calendar Year 2018, 1/1/2018 – 12/31/2018.
206.	IV. P.2 Capitation Rate Determination Process	143	Please describe any adjustments made in the initial (1/1/17-6/30/17) capitation rate development to account for breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval during the rating period.	No adjustments were made for breakthrough therapies. These treatments are reflected in the capitation rate to the extent they were provided in the base data. In addition, the pharmacy trend is higher than historical, in part due to the emergence of breakthrough therapies.
207.	IV. P.2 Capitation Rate Determination Process	143	Please describe any analyses/monitoring expected to be performed to measure and/ or predict the impact of breakthrough therapies which have newly gained FDA approval and/ or are expected to gain FDA approval as part of future rate development processes.	Prior to development of the final rate the State's actuary will reexamine emerging treatments that could be impactful on MCO pharmacy expenses. Historic experience will be adjusted as necessary to appropriately account for the anticipated impact of breakthrough treatments.
208.	IV. P.2 Capitation Rate Determination Process	143	One of the adjustments listed as being considered as part of the rate development is	See response to Question # 158.

			"Coordinated Care Savings." Please clarify these items and their values reflected in the initial rate development. If there are any such adjustments included within the initial rate development, please separate them between those adjustments applied to the existing managed care data and FFS, and further break down by region, category of service, and category of aid for both utilization and unit cost.	
209.	IV. P.2 e. Capitation Rate Determination Process	143	"This section of the RFP states that ""Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from State fiscal years 2013, 2014, and 2015." a) Please provide a detailed narrative and numerical exhibits (by fiscal year, data source, and rate cell) to describe the ways in which these multiple data sources were incorporated.	FY2013 data was only used for trend development. FY14 and FY15 data was blended together to create the two-year base data. Supplementary financial statements were used to validate the Managed Care Entity encounter data and to build in supplement, non-claims expense (such as CAH settlement payments). The data sources are used as follows: Physical Health Encounters are used for Physical Health services for populations currently enrolled in Physical Health managed care. Behavioral Health Encounters are used for Behavioral Health services for all populations. Fee-for-service data is used for pharmacy data for all populations and Physical Health services for populations not currently enrolled in Physical Health managed care (e.g. Duals, LTSS, Women with Cancer). More details can be found in Attachment 22: "Heritage Health Rate Development Narrative". Data was not adjusted for underreporting. IBNR adjustment values can be found in Attachment 25: "IBNR Assumptions by Source". Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statements. The IBNR estimates reported on the financial statements were also

			b) Please clarify the values used to adjust each of these data sources for both IBNP and underreporting, and describe how the current MCOs provided input into these estimates. c) Please list and provide values for additional adjustments made to create the base data shown in Attachments 10-A and 10-B. d) Please describe how 2013 data is used to develop the initial rates. e) Please describe how the data was validated/reconciled, the sources used, and the results of the validation/reconciliation. f) Please describe how FY2015 and FY2016 data was adjusted and merged together. g) Please provide detailed information regarding any non-encounter based costs included in the base data such as provider incentives or value based agreements"	used to verify the accuracy of the IBNR adjustments, and these values were discussed with current MCOs. The only adjustments made to the encounter data to create the base data shown in Attachment 10-A and 10-B are IBRN, Supplemental Payments, and Subcapitation Expenses. IBNR is detailed in Attachment 25: "IBNR Assumptions by Source". Across both FY14 and FY15 Supplemental Payments are worth $11.2 million on a statewide basis and Subcapitation Expenses are work $13.8 million on a statewide basis. Subcapitation represents predominantly Vision subcapitated agreements, while Supplemental Payments represent non-claims payments, such as CAH settlements. FY13 data is used only in the development of trend. Current MCOs were involved in validating the encounter data to ensure it was fully reported and consistent with their financial statement. The IBNR estimates reported on the financial statements were also used to verify the accuracy of IBNR adjustments, and these values were discussed with current MCOs. FY16 data was not used. FY15 data was blended with FY14 data to develop the base data. Non-encounter expenditures such as CAH settlements or PCP shared risk agreements are included as part of the Supplemental Payments adjustment described earlier in the question response.
210.	IV. A.1.a	page 30	The RFP states that DHHS is	RFP 5151 Z1 only applies to the MLTC division.

			comprised of 6 divisions. Please describe the process used to capture all of the expenses from each division.	
211.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. What reconciliation process did DHHS and Optumas use to ensure all expenses were captured from each of these divisions?	See response to Question #210.
212.	IV. A.1.a	page 30	The RFP states that DHHS is comprised of 6 divisions. Please provide the reconciliation used to ensure all expenses were captured from each of these divisions.	See response to Question #210.
213.	IV.P.2. Capitation Rate Determination Process	143	A number of detailed analyses and narratives are described in this section related to the certification of capitation rates. We appreciate that this detail will be provided to MCOs and we understand that the final documents for the initial rate period will not be available until after the contract is awarded. However, in order to understand the development of the rates, we need to have a draft version of all of these documents that would tie out to the rates	See Attachment 22: "Heritage Health Rate Development Narrative", and Attachment 20: "COA-level Rate Development" for additional detail into the rate development process.

			shown in attachment 11, and which would include all adjustments, data, and trends to the level of detail used by the actuary as soon as possible. In particular, a number of disclosure requirements are outlined in the 2016 Medicaid Managed Care Rate Development Guide. Please ensure that your documentation reflects these requirements in order for bidders' to fully understand the rate development.	
214.	IV. P.2 h. Capitation Rate Determination Process	143	"This section states that the annual capitation review will include ""an analysis of any anticipated fee schedule changes or other programmatic changes to the HERITAGE HEALTH."" a) Please confirm that the intent of this analysis is to update rates proactively in advance of anticipated policy changes or fee schedule changes. b) Please provide this analysis, particularly of anticipated fee schedule and other programmatic changes, and how they have been	Capitation rates will be developed inclusive of any known or anticipated policy changes and fee schedule changes. The fee schedule changes built in to these rates include a 2.25% annual increase in reimbursement for Behavioral Health services and a 2% annual increase in reimbursement for Physical Health services. The provider increases are legislatively-mandated fee schedule changes. Recently these changes have been 2.25% and 2.0% for Behavioral Health and Physical Health services respectively, but that has not always been the case and is not guaranteed to continue. For projection to the Heritage Health contract period the contracted actuary assumed the annual increases will remain consistent. The Behavioral Health provider increase was applied by increasing data to reflect the number of fee schedule changes between the data time period and the contract period. For example, FY14 reimbursement was increased by 2.25% to reflect FY15 reimbursement levels. Then, the combined FY14/FY15 base (already adjusted to be at FY15 legislatively-mandated reimbursement levels) was increased for two more 2.25% fee schedule changes, one effective July 2015

			incorporated into this initial rate development. c) Please list and provide historical values and anticipated effective dates of any automatic fee schedule updates."	and another anticipated to be effective July 2016. Finally, due to the 12-month calendar year contract period, one-half of the 2.25% program change anticipated to be effective July 2017 was applied. The Physical Health provider increase was applied as unit cost trend for Physical Health Services. Recently the Behavioral Health fee schedule change has been 2.25% annually and the Physical Health fee schedule change has been 2.0% annually. The current rate development assumes these values will remain in effect until the CY2017 contract period. If the values are changed by future legislative sessions rates will be updated accordingly.
215.	IV P.5. Supplemental Delivery Payments	144	"Questions related to delivery payments: a) Please comment on the decision not to pay a supplemental kick for stillbirths, especially given the fact that the payment covers the mother's prenatal care, postpartum care, and the delivery, which can be the same or higher than a healthy delivery in the event of a stillbirth. b) Please also confirm that the rate was built exactly how the payment policy is outlined."	The supplemental maternity payment rate is established based on MLTC policy.
216.	IV P.5. Supplemental Delivery Payments	144	Please confirm payment of the maternity kick payment when there is no hospital	In the absence of a hospital inpatient stay, the MCO may submit other inpatient or outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment. Costs associated with inpatient and outpatient maternity care are

			inpatient stay (e.g., situations when the mother deliveries at a birth center (non-inpatient) or at home), but a baby was delivered. Please also clarify how these types of events were reflected in the data.	included in capitation rate development.
217.	IV P.5. Supplemental Delivery Payments	144	"Please confirm which services are covered by the supplemental delivery payment: a) would all services (e.g., visits for broken leg) provided during the prenatal and postpartum period be covered, or only maternity related costs? b) If all costs are included within the supplemental delivery payment, please explain how the capitation rates for the relevant categories of aid are reduced for this payment. c) If only maternity related costs are included within the supplemental delivery payment, please explain why the exhibit for maternity services includes many of the same services covered by the monthly capitation rate payments (e.g. home health	a) All services b) The delivery window (5 months pre-delivery and 2 months post-delivery) is identified in the claims data. Any medical expense that falls within that window is re-classified from the original category of aid and into the Maternity case rate. c) See a above.

			and vision)."	
218.	IV. P.3 b Capitation Rates And Payment	144	Please describe in greater detail how partial months of enrollment are calculated for capitation payment purposes	Enrollment into managed care is monthly.
219.	IV. P.3 b Capitation Rates And Payment	144	Please confirm that member months are calculated in an identical fashion for the data book, capitation rate development and capitation payment purposes.	Confirmed.
220.	IV. P.8 Risk Adjustment	145	The RFP states: "For subsequent years of the contract, each MCO's proposed base capitation rates will be risk-adjusted based on the MCO's risk score…" Please clarify whether risk adjustment will start on 1/1/18 or 7/1/17.	The risk adjustment tool will be considered for the second contract period, beginning 1/1/18.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FIVE
REVISED SCHEDULE OF EVENTS

Date: November 18, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 16, 2015~~ **November 18, 2015**
6	Form B Notification of Intent to Attend Second Pre-Proposal Conference	November 17, 2015
7	Second Pre-Proposal Conference will be held at Location: Lincoln Medical Educational Partnership 4600 Valley Road Lincoln, NE 68510 **Attendance at Pre-Proposal Conference is optional** Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 4533256#	November 19, 2015 1:00 PM - 4:00 PM Central Time
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FOUR
REVISED SCHEDULE OF EVENTS

Date: November 17, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 16, 2015~~ **November 18, 2015**
6	Form B Notification of Intent to Attend Second Pre-Proposal Conference	November 17, 2015
7	Second Optional Pre-Proposal Conference Location: Lincoln Medical Educational Partnership 4600 Valley Road Lincoln, NE 68510 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 4533256#	November 19, 2015 1:00 PM - 4:00 PM Central Time
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM THREE
REVISIONS TO RFP

Date: November 10, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

The following is hereby amended as follows:

Document	Section	Change From:	Change to:
RFP	IV.E.29.h	Add new section	Non-emergency transportation (except as indicated in Section IV.E.8.a)
RFP	IV.B.3.e	In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment.	In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment during the initial Heritage Health enrollment period.
RFP	IV.A.11.f	Add new section	Inmates of public institutions.
RFP	IV.B.10.a.iv	Remove section	
RFP	IV.F.10.f	Us of proprietary items that would require use of a specific browser or other interface is not allowed.	Use of proprietary items that would require use of a specific browser or other interface is not allowed.

RFP	IV.C.1.b	On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must include in its proposal: i. An analysis of the Proposed Rule that includes the MCO's interpretation of all provisions relevant to the contract requirements. ii. A plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.	On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must submit 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier), a plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.
RFP	Glossary of Terms	**Primary care provider (PCP):** A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.	**Primary care provider (PCP):** A medical professional chosen by or assigned to the member to provide primary care services. Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.
RFP	Glossary of Terms	**Primary care services:** All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.	**Primary care services:** All health care services and laboratory services customarily furnished by or through primary care provider, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Attachment 5		**Required with Proposal:** Proposed Rule Implementation Plan **Description:** Plan for complying with new CMS Medicaid managed care rules as described in Section IV.C – Business Requirements **Due Date:** Required with proposal	**90 Days Prior to Contract Start Date:** Proposed Rule Implementation Plan **Description:** Plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance. **Due Date:** 90 days prior to the contract start date or 60 days after the Proposed Rule is finalized (whichever is earlier).
Attachment 4	Core Competency 1	Core Competency 1: Facilitate ongoing patient relationship with physician in a physician-directed team.	Core Competency 1: Facilitate ongoing patient relationship with a primary care provider in a physician-directed team.
Attachment 4	Core Competency 1	6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.	6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care provider(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWO
REVISED SCHEDULE OF EVENTS

Date: November 9, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6	**Form B Notification of Intent to Attend Second Pre-Proposal Conference**	**November 17, 2015**
7	Second **Optional** Pre-Proposal Conference Location: **Lincoln Medical Educational Partnership** **4600 Valley Road** **Lincoln, NE 68510** **Call-in information for those unable to be present is as follows:** **Conference Access Number: (888) 820-1398** **Attendee Code: 4533256#**	**November 19, 2015** **1:00 PM - 4:00 PM** **Central Time**
8	Last day to submit Second Round written questions	November 23, 2015
9	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
10	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
11	Review for conformance of mandatory requirements	December 22, 2015
12	Evaluation period	January 6, 2016 – January 22, 2016
13	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
14	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016

	ACTIVITY	DATE/TIME
15	Contract finalization period	January 29, 2016 – February 29, 2016
16	Contract award	March 1, 2016
17	Contractor start date	January 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

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Form B

Notification of Intent to Attend Second Pre-Proposal Conference

Request for Proposal Number 5151 Z1

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Fax Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivered or US Mail by the date shown in the Schedule of Events.

NEBRASKA
Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM ONE
QUESTIONS and ANSWERS

Date: October 23, 2015

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5151 Z1
to be opened December 22, 2015 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

QUESTIONS	ANSWERS
1. Is the Pre-Proposal Conference on Monday for Prospective Bidders only or may stakeholders such as my organization attend as well?	Anyone may attend the pre-proposal conference on Monday, October 26.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Attachment 19
Proposal Statements and Questions

No.	RFP Section	Statement/Question	Page Limit
1.	Not applicable	If applicable, describe the MCO's proposed risk bearing partnerships/relationships including designated functions of each entity, and how delegated functions will be overseen.	2 pages
2.	Not applicable	Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	Not applicable
3.	Not applicable	State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	Not applicable
4.	III.G. Insurance Requirements	Describe the risk analysis, assumptions, cost estimates and rationale supporting the MCO's proposed reinsurance arrangements. If any reinsurance is provided through related parties, provide a disclosure of the entities and details causing the related party relationship.	2 pages
5.	IV.B Eligibility and Enrollment	Provide a comprehensive discussion of the MCO's approach to maximizing the number of members who have a relationship with a PCP, including: • The strategy the MCO will use initially, and on an ongoing basis, to ensure PCP selection within 30 calendar days. • Examples of successful strategies and lessons learned in encouraging PCP relationships.	2 pages
6.	IV.B Eligibility and Enrollment	Describe the MCO's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records.	1 page

No.	RFP Section	Statement/Question	Page Limit
7.	IV.B Eligibility and Enrollment	Describe the interventions the MCO will use prior to seeking to disenroll a member who requests disenrollment outside the annual open enrollment period. Provide examples of scenarios in which the MCO has effectively intervened to avert disenrollment of a member or members.	2 pages
8.	IV.B Eligibility and Enrollment	Describe the MCO'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.	1 page
9.	IV.B Eligibility and Enrollment	Describe the MCO's approach to working with other MCOs in the event a member changes his/her MCO during ongoing operations of the program. Describe how the MCO will work with other MCOs to ensure a seamless transition and transfer of relevant information.	1 page
10.	IV.B Business Requirements	Describe the approach the MCO will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.	Not applicable
11.	IV.C Business Requirements	Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance.	1 page, excluding copy of COA
12.	IV.C Business Requirements	Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6.	3 pages
13.	IV.C Business Requirements	Describe if any of the MCO's 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.	1 page
14.	IV.C Business Requirements	If applicable, describe any restriction of coverage for counseling or referral services the MCO is required to provide because of moral or religious obligation. Describe how the MCO will provide members with access to those services.	1 page
15.	IV.D Staffing Requirements	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.	3 pages, excluding organizational chart
16.	IV.D Staffing Requirements	Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational	Not applicable

No.	RFP Section	Statement/Question	Page Limit
		Chart."	
17.	IV.D Staffing Requirements	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."	Not applicable
18.	IV.D Staffing Requirements	Provide job descriptions (including education and experience qualifications) of employees in key staff positions.	1 page per job description
19.	IV.D Staffing Requirements	Describe how the MCO's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, and pharmacy services.	4 pages
20.	IV.D Staffing Requirements	Describe how the MCO 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.	6 pages
21.	IV.D Staffing Requirements	Describe how the MCO will coordinate with the MLTC Dental Benefits Manager, including processes for reciprocal referral for needed services. Include the MCO's plan to identify a dental services liaison.	2 pages
22.	IV.E. Covered Services and Benefits	Provide the MCO'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.	3 pages
23.	IV.E Covered Services and Benefits	Provide a description of the value added services the MCO proposes to offer to members. 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	Not applicable

No.	RFP Section	Statement/Question	Page Limit
		be notified of the service's availability. • Describe how a member may obtain/access the service. • Describe how the MCO will identify the expanded benefit in administrative or encounter data.	
24.	IV.E Covered Services and Benefits	Describe the MCO's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the MCO's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established timeframes.	4 pages
25.	IV.E Covered Services and Benefits	Describe the MCO'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 MCO's utilization management strategies.	3 pages
26.	IV.E Covered Services and Benefits	Describe the MCO's experience with an integrated pharmacy benefit in other states and specify the type of plan and enrollment. Provide a preliminary work plan identifying key milestones, tasks, and accountability for implementation of Pharmacy Services as described in the RFP.	3 pages, excluding preliminary work plan
27.	IV.E Covered Services and Benefits	Describe how the MCO will ensure compliance with the Mental Health Parity and Addiction Equity Act, including how the MCO will evaluate and measure its compliance.	3 pages
28.	IV.F Member Services and Education	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 on-line 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.	6 pages
29.	IV.F Member Services	Describe the informational materials the MCO proposes	2 pages

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	and Education	to send to new members.	
30.	IV.F Member Services and Education	Describe the approach the MCO will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the MCO will ensure that materials are at the appropriate reading level.	2 pages
31.	IV.F Member Services and Education	Provide an overview of the MCO's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members.	6 pages
32.	IV.F Member Services and Education	Discuss the MCO's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the MCO would use to effectively welcome members.	3 pages
33.	IV.F Member Services and Education	Detail the strategies the MCO will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles.	5 pages
34.	IV.F Member Services and Education	Describe the processes the MCO will put in place to ensure the MCO does not restrict the choice of providers from whom the member may receive family planning services and supplies.	1 page
35.	IV.F Member Services and Education	Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the MCO has used for member education. Describe how the MCO 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.	10 pages
36.	IV.H Grievances and Appeals	Provide a flowchart and comprehensive written description of the MCO'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	3 pages

No.	RFP Section	Statement/Question	Page Limit
		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 MCO will determine when the expedited process is necessary. • Use data from the grievance and appeals system to improve the MCO's operational performance.	
37.	IV.H Grievances and Appeals	Describe the approach the MCO will take to provide members with grievance, appeal, and State fair hearing information. Address how the MCO 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.	2 pages
38.	IV.I Provider Network Requirements	Describe the MCO'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 IV.I. Describe the method the MCO 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 behavioral health providers. • Inclusion of high volume specialists. • Inclusion of FQHCs and RHCs. • Inclusion of urgent care centers. • Inclusion of pharmacies. • Inclusion of hospitals.	6 pages, excluding plan for developing an adequate network
39.	IV.I Provider Network Requirements	Describe the MCO's required PCP responsibilities and how the MCO will verify PCPs are performing them.	2 pages
40.	IV.I Provider Network Requirements	Describe innovative strategies the MCO's intends to use to identify specialty types for which member access is limited. Describe the MCO's intended initiatives for increasing the number of specialists within those specialty types that participate in the MCO's network. Identify potential challenges the MCO anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the MCO will mitigate those challenges.	3 pages

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41.	IV.I Provider Network Requirements	Describe the MCO's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times.	2 pages
42.	IV.I Provider Network Requirements	Describe the MCO's approach to promoting and facilitating the capacity of its providers to provide: • Patient-centered care. • Improved health outcomes. • Member compliance. • Member satisfaction. Discuss the MCO's successes with patient-centeredness in other Medicaid programs, what lessons have been learned, and the MCO's planned approach in Nebraska.	3 pages
43.	IV.I Provider Network Requirements	Describe how the MCO's network development plan will establish patient-centered medical homes consistent with the requirements included in Section IV.I Provider Network Requirements. The description must address requirements in the RFP including: • Promoting and facilitating provider capacity to meet PCMH standards. • Maintaining contact with members throughout their interactions with the health care system. • Managing referrals. • Illness and disease prevention. • Encouraging active participation of the member or family/guardian/authorized representative in health care decision-making • Encouraging the use of specialty services and supports. • Providing access to care outside normal business hours. • Facilitating open scheduling and same-day appointments where possible.	5 pages
44.	IV.I Provider Network Requirements	Describe how the MCO 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 PBM. • 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.	3 pages

No.	RFP Section	Statement/Question	Page Limit
45.	IV.I Provider Network Requirements	Describe the MCO's credentialing and re-credentialing process including: • Ensuring that providers are enrolled in Medicaid and have a valid identification number. • Obtaining information on ownership and control. • Identifying excluded providers and persons convicted of crimes searches. • Using quality and utilization measures in the recredentialing process.	3 pages
46.	IV.I Provider Network Requirements	Explain the process the MCO 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.	2 pages
47.	IV.J Provider Services	Provide a description of the MCO's provider services program/department and how the MCO 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 MCO will form for providers to offer input regarding issues such as the MCO's service delivery, MCO/provider interactions, and potential opportunities/ innovations for improved health outcomes. • Description of how the MCO will develop, establish and maintain its provider advisory committee, with representation as identified in this RFP. • Sample provider outreach methods.	4 pages
48.	IV.J Provider Services	Describe the MCO's Provider Services toll-free telephone line, including: • How the MCO will provide a fully-staffed line between the hours of 7:00 a.m. and 8:00 p.m. CST. Monday through Friday, to address non-emergency issues and how the MCO will provide a clinical pharmacist staffed at all times during the hours of 8:00 a.m. and 8:00 p.m. CST Monday through Friday. • How the MCO 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 MCO will accommodate services for Nebraska. • How the MCO will measure and monitor the	3 pages

No.	RFP Section	Statement/Question	Page Limit
		accuracy of responses provided by call center staff, as well as caller satisfaction.	
49.	IV.J Provider Services	Provide an overview of the MCO's proposed provider website, including examples of information that will be available on the website and on portals for providers. Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website.	5 pages excluding sample resources, tools and materials
50.	IV.J Provider Services	Describe the MCO's proposed provider education and training program, including: • A description of the training program. • A work plan that outlines education and training activities, including frequency of office visits to conduct activities. • A listing of the types of materials and content the MCO will distribute (include three samples of materials). • How the MCO will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.	5 pages, excluding sample materials
51.	IV.J Provider Services	Describe the MCO's proposed approach to promoting communication between providers and the MCO. Include a discussion of how the MCO 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 trainings, and enhance MCO-provider communication strategies. Provide examples of how the MCO has successfully collaborated with providers to identify necessary changes and how these changes have been implemented.	2 pages
52.	IV.J Provider Services	Provide a description of the MCO's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the MCO will acknowledge and resolve inquiries and grievances. Explain how the MCO will track provider complaints and how the MCO will use this type of information to improve provider services. Include a description of any type of internal reporting the MCO will perform, and how the MCO will use reporting information to influence the activities of the MCO's provider services representatives.	3 pages
53.	IV.J	Describe the MCO's plans and ability to support network providers' "meaningful use" of electronic health records	1 page

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	Provider Services	and current/future Federal IT requirements.	
54.	IV.J Provider Services	Discuss how the MCO will engage and educate PCPs about their role in the provision of behavioral health services and the coordination of co-existing conditions.	2 pages
55.	IV.J Provider Services	Describe the approach the MCO will take to assess provider satisfaction, including tools the MCO plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	5 pages
56.	IV.K Subcontracting Requirements	For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following: • The date the company was formed, established or created. • Ownership structure (whether public, partnership, subsidiary, or specified other). • Organizational chart. • Total number of employees. • Whether the subcontractor is currently providing services for the MCO in other states and the subcontractor's location.	1 page per subcontracting organization
57.	IV.K Subcontracting Requirements	For subcontracted roles included in the proposal, describe the MCO's process for monitoring and evaluating performance and compliance, including but not limited to how the MCO will: • Ensure receipt of all required data including encounter data. • Ensure that utilization of health care services is at an appropriate level. • Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP. • Ensure adherence to required grievance policies and procedures. • Ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC.	8 pages
58.	IV.L Care Management	Provide a comprehensive discussion of the MCO's care management program, including: • Coordination of services using person-centered strategies.	Not applicable

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		• Interventions focused on the whole person. • Management of co-morbidities. • Incorporation of best practices for behavioral health. • Member engagement in self-management strategies. • Social determinants of health, including risk and protective factors for behavioral health concerns. • Identification and tracking of members whose clinical conditions or social factors place them at an increased risk for circumstances necessitating a higher level of care management services. Provide case studies and experience from other states illustrating the MCO's ability to successfully address community differences in its care management approach.	
59.	IV.L Care Management	Describe the MCO's approach for identifying members in need of care management services, including: • The proposed process for providing a health risk screening to all members upon enrollment to identify and assess members potentially eligible for care management services, including those who have or are likely to experience catastrophic or other high-cost or high-risk conditions. • A description of the algorithms and methodologies the MCO will use to identify members potentially eligible for care management. • The proposed process for conducting health risk assessments for members identified as potentially eligible for care management. Submit the proposed health risk assessment template that the MCO plans to use.	5 pages
60.	IV.L Care Management	Describe the specific types of services members will receive at each risk level. Provide recommendations for additional innovative care management strategies, if any, MLTC may want to consider.	5 pages
61.	IV.L Care Management	Describe how the MCO will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover.	2 pages
62.	IV.L Care Management	Describe the MCO's strategy to address the unique challenges when coordinating care for dual-eligible individuals who receive their services from both Medicare and Medicaid.	2 pages
63.	IV.L Care Management	Describe the process for care coordination for members who are Tribal members or are otherwise eligible for care through Indian Health Services.	1 page
64.	IV.L	Describe how the MCO will coordinate service planning, service delivery, and post-discharge care among	4 pages

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	Care Management	discharge planners (including State psychiatric hospitals) and home health and other service providers. Include the MCO's approach to care management for youth discharged from residential care. Explain how the MCO will monitor the post-discharge care of members who receive services in remote areas.	
65.	IV.L Care Management	Describe how the MCO will use data and evidence-based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies. Discuss how these tools and data and systems will be integrated to implement outcome- and value-oriented payment models. Describe the MCO's experience and specific results.	5 pages
66.	IV.L Care Management	Provide a proposed plan for coordinating efforts for members who may be involved in multiple State programs, including those enrolled in HCBS waivers. Describe how the MCO will deploy care management activities under this RFP in a manner that will not duplicate the activities provided under HCBS waivers and will facilitate sharing of information across DHHS-administered programs.	3 pages
67.	IV.L Care Management	Describe the MCO's outreach program to encourage women to seek prenatal services during their first trimester of pregnancy and how the MCO will implement required health risk screening and follow up, when applicable, for pregnant members.	2 pages
68.	IV.M Quality Management	Provide a description of the MCO's proposed QAPI program. Include the following in the description: • The proposed structure, and policies and procedures that explain the accountability of each organizational unit. • The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable. • Proposed QAPIC membership and committee responsibilities. • How the MCO will comply with and support MLTC's quality strategy. • How focus areas will be selected, including how data will be used in the selection process. • The proposed QAPI work plan, including planned initiatives.	10 pages
69.	IV.M Quality	Describe how the MCO will measure and track the outcome of individual quality improvement interventions	3 pages

No.	RFP Section	Statement/Question	Page Limit
	Management	over time.	
70.	IV.M Quality Management	Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes.	5 pages
71.	IV.M Quality Management	Describe how the MCO will assess the quality and appropriateness of care furnished to members with special health care needs, members with co-occuring physical and behavioral health concerns, and dual-eligible members.	3 pages
72.	IV.M Quality Management	Describe the MCO's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the MCO's quality of care.	2 pages
73.	IV.M Quality Management	Describe the MCO's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the MCO, and how operations improved because of their results. Discuss how the MCO will collaborate with MLTC and other MCOs to conduct statewide PIPs.	3 pages
74.	IV.M Quality Management	Discuss the MCO's approaches to annual member satisfaction surveys. Provide relevant examples of how the MCO has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	1 page
75.	IV.M Quality Management	Discuss the MCO's experience with submitting HEDIS measures. Indicate whether the measures were reported for a State Medicaid, CHIP, or commercial product line.	1 page
76.	IV.M Quality Management	Provide the MCO's vision for the MCO's Clinical Advisory Committee. Discuss how the requirements of the RFP will be met.	2 pages
77.	IV.M Quality Management	Describe the MCO's practice of profiling the quality of care delivered by PCPs, specialists, and hospitals, including the methodology for determining which and how many providers will be profiled. • Submit sample quality reports. • Describe the rationale for selected the measures that are gathered/reported. • Describe the proposed frequency of profiling activities.	3 pages, excluding sample quality reports

No.	RFP Section	Statement/Question	Page Limit
78.	IV.M Quality Management	How will the MCO use the Member Advisory Committee to improve quality of care and direct quality and operational changes? What representation does the MCO plan to have on each committee (e.g., stakeholder types, from what geographic areas)? How will the MCO identify participants of the Member Advisory Committees? Provide examples from other states where the MCO has collaborated with members for program improvement.	5 pages
79.	IV.M Quality Management	Describe the information the MCO will provide to members and providers about the QAPI program.	2 pages
80.	IV.N Utilization Management	Describe the MCO's approach to utilization management, including: • Innovations and automation the MCO will use for its UM program. • Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers. • Mechanisms to detect and document over- and under-utilization of medical services. • Processes and resources used to develop and regularly review utilization review criteria. • How the MCO will use its UM Committee to support UM activities.	5 pages
81.	IV.N Utilization Management	Describe the process the MCO will have in place to determine appropriate practice guidelines (including for behavioral health), notify providers of new practice guidelines, and monitor implementation of those guidelines.	2 pages
82.	IV.N Utilization Management	As one of the largest payers in Nebraska, MLTC has an important role to play to move the health care system to a more cost-effective model that improves outcomes. Provide specific initiatives the MCO will pursue to deal with "waste" in the existing system and improve outcomes. Provide specific information regarding the initiatives that will be pursued to improve quality and enhance cost containment (including the stakeholders involved, the timelines, and the desired outcomes).	4 pages
83.	IV.N Utilization Management	Describe the MCO's proposed approach to prior authorization, including: • The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation	4 pages

No.	RFP Section	Statement/Question	Page Limit
		of need for current prior authorization requirements. • The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization. • The role of the Clinical Advisory Committee in developing service authorization procedures. • The MCO's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.	
84.	IV.N Utilization Management	Provide a listing of services for which the MCO will require prior authorization and describe how the MCO will communicate this information, as well as the results of authorization decisions, to providers and members.	2 pages excluding the listing of services
85.	IV.N Utilization Management	Describe how the MCO will ensure members receive written and timely notice of action relating to adverse actions taken by the MCO.	1 page
86.	IV.N Utilization Management	Describe the MCO's process for conducting concurrent reviews for inpatient services.	2 pages
87.	IV.N Utilization Management	Describe the MCO's process for conducting retrospective reviews to examine trends, issues, and problems in utilization.	2 pages
88.	IV.N Utilization Management	Describe the initiatives the MCO will implement to control unnecessary ED utilization, avoidable hospitalizations, and hospital readmissions. Discuss how the MCO will ensure that care is provided in the most appropriate and cost effective setting. Include strategies that address access to primary care services through patient centeredness principles; the use of urgent care centers and retail clinics; and, interventions targeted to super-utilizers, such as patients with asthma, diabetes, chronic pain, and/or behavioral health conditions.	6 pages
89.	IV.N Utilization Management	Describe the MCO's proposed MTM program, including a description of the inclusion criteria that the MCO proposes to use. Also, include any vendor(s) that will be subcontracted by the MCO to perform or support MTM services. Provide a detailed description of tools the MCO will use to ensure the active engagement of the retail pharmacies in the MTM program.	4 pages
90.	IV.N Utilization Management	Describe the MCO's DUR program including prospective and retrospective DUR activities. Include a description of: • Prescriber and pharmacy education programs.	3 pages

No.	RFP Section	Statement/Question	Page Limit
		• Collaboration with MLTC's DUR. • How DUR results will be used to inform MTM education and outreach.	
91.	IV.N Utilization Management	Describe the MCO's proposed psychotropic drug oversight program to ensure appropriate utilization, including a description of the inclusion criteria that the MCO proposes to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of: • Tools to monitor and measure psychotropic prescribing patterns and usage. • Processes to actively engage retail pharmacies and pharmacists in the oversight program. • Plans for prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member. • Processes to ensure that psychotropic medications prescribed to children are being used appropriately and for the indicated diagnosis.	4 pages
92.	IV.N Utilization Management	Describe the MCO's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities.	2 pages
93.	IV.O Program Integrity	Describe the MCO's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the MCO has utilized in other states.	4 pages
94.	IV.O Program Integrity	Describe how the MCO currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the MCO apply methods in Nebraska?	2 pages
95.	IV.O Program Integrity	Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the MCO apply methods in Nebraska?	3 pages
96.	IV.O Program Integrity	Describe the MCO's method and process for capturing TPL and payment information from its claims system. Explain how the MCO will use this information.	3 pages
97.	IV.Q Provider Reimbursement	Provide a detailed description of the MCO's approach to implementing a value-based purchasing model with providers. Include at a minimum the MCO's:	6 pages

No.	RFP Section	Statement/Question	Page Limit
		• Philosophy regarding value-based purchasing and risk-sharing agreements and evidence of effective use in Nebraska or other markets • Approach to identifying initiatives and performance measures on which to focus, proposed engagement strategies to encourage provider participation, incentives the MCO will use, and methodology and timing for determining if providers have met requirements • Plan for entering into value-based purchasing agreements with 30% of its provider network by December 31, 2019. • Discussion of best practices and lessons learned.	
98.	IV.Q Provider Reimbursement	Provide a description of the MCO's proposed MAC program, including methods for setting MAC prices, criteria used to select covered MAC drugs, process for resolving disputes regarding the MAC value, how the MCO will evaluate its MAC program, and any other program components the MCO considers important for achieving the State's NMMCP goals. Describe the MCO's experience with establishing MAC programs in other states, and highlight strengths and challenges.	6 pages
99.	IV.Q Provider Reimbursement	Describe the MCO's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the MCO is unable to provide necessary services to a member within its network.	2 pages
100.	IV.Q Provider Reimbursement	Describe the MCO's proposed process for the annual year-end cost settlement process with critical access hospitals.	1 page

No.	RFP Section	Statement/Question	Page Limit
101.	IV.R Systems and Technical Requirements	Provide a general system description that details how each component of the MCO's health information system will support the major functional areas of NMMCP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements. Describe how the MCO's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the MCO's systems. If modifications or updates or updates are required, describe them and the MCO's plan for completion prior to program operations.	12 pages, not including the systems diagram
102.	IV.R Systems and Technical Requirements	Provide a description of how the MCO will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the MCO's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the MCO's internal membership records, including differences in members' addresses.	3 pages
103.	IV.R Systems and Technical Requirements	Describe the MCO's approach to monitoring system availability issues and the resolution process. Provide a description of the MCO's system help desk. Include the MCO's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to MCO management within one business day of recognition and are promptly corrected.	2 pages
104.	IV.R Systems and Technical Requirements	Provide a description of the MCO's eligibility and enrollment database. Include a description of how the MCO will: • Complete updates within the timeframes specified in the contract. • Identify members across multiple populations and systems. • Monitor, track, and resolve any discrepancies between the enrollment files and the MCO's system (e.g., duplication of records and information mismatches).	2 pages

No.	RFP Section	Statement/Question	Page Limit
105.	IV.R Systems and Technical Requirements	Provide a description of the MCO's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities.	3 pages
106.	IV.R Systems and Technical Requirements	Describe the MCO's business continuity, contingency, and recovery planning. Attach a copy of the MCO's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery: • Operational and system redundancy in place to reduce the risk of down-time. • System and operational back-up sites. • Contingency and recovery planning including resumption of operations. • Prioritized business functions for resumption of operations and responsible key personnel. • Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable. • Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith. • Testing approach and regular schedule to improve and update the plan over time.	3 pages, excluding sample plan
107.	IV.S Claims Management	Describe the MCO's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the MCO's strategy for identifying problem areas, and how the MCO will ensure rapid response.	2 pages
108.	IV.S Claims Management	Describe the MCO's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address: • The process for auditing claims samples. • Documentation of the results of these audits. • The processes for implementing any necessary corrective actions resulting from the audit.	3 pages
109.	IV.S Claims	Describe in detail how the MCO will verify that services were actually provided including:	3 pages

No.	RFP Section	Statement/Question	Page Limit
	Management	• Minimum sampling criteria to ensure a representative sample. • How results of monitoring will be reported to the State quarterly.	
110.	IV.S Claims Management	Describe the drug reference database used in pharmacy claims processing, and the update schedule, including term dates, obsolete dates, and rebate status.	2 pages
111.	IV.S Claims Management	Describe how the State Medicaid PDL will be integrated into the MCO pharmacy claims system.	2 pages
112.	IV.S Claims Management	Describe the MCO's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the MCO proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor.	5 pages
113.	IV.S Claims Management	Describe the MCO's proposed processes for coordination of benefits for dually-eligible members.	2 pages
114.	IV.T Reporting and Deliverables	Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAPI Committee.	Not applicable
115.	IV.T Reporting and Deliverables	Provide examples of the following reports: Member Grievance System Performance Improvement Projects Care Management How will the MCO use required reports in its day to day management and operations?	Not applicable
116.	IV.X Transition and Implementation	Describe how the MCO will coordinate the initial transition of individuals in the follow situations to ensure continuity of care: • From another MCO. • From FFS , including specific approaches for the aged and disabled populations who are new to managed care. Include processes for engaging existing providers in the transition.	5 pages
117.	IV.Z FFS Claims Management and Processing	Provide a detailed description of the MCO's approach to implementing the necessary functionality to support FFS claims processing.	Not applicable

No.	RFP Section	Statement/Question	Page Limit
118.	IV.Z FFS Claims Management and Processing	Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.	Not applicable
119.	IV.Z FFS Claims Management and Processing	Describe how the MCO will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.	Not applicable
120.	IV.Z FFS Claims Management and Processing	Provide an explanation of the MCO's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?	Not applicable
121.	IV.Z FFS Claims Management and Processing	Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.	Not applicable
122.	IV.Z FFS Claims Management and Processing	Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.	Not applicable

Attachment 18 – Liquidated Damages

Failed Deliverable	Penalty
Readiness Review	MLTC will conduct a formal review of the MCO's readiness to implement all required services described in this RFP. Should the MCO fail the review, MLTC may assess damages of $5,000 for each calendar day until such time as MLTC certifies that the MCO has met all readiness requirements.
Date of Implementation	Should the MCO fail to begin full operations on the contract start date, and should MLTC determine that the MCO is responsible for the delay, MLTC may assess damages of $10,000.00 per calendar day for each day beyond the contract start date that the MCO fails to begin full operations.
Network Performance Requirement	The MCO must have a contracted provider network in place and submit the required attestation of network sufficiency 90 calendar days prior to the contract start date. A penalty of $1,000.00 shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations as described in Section X - Provider Network and the attestation of network sufficiency has not been received.
Employment of Key Personnel	The MCO must meet all key personnel requirements specified in Section X of this RFP. MLTC may assess a penalty of $1,000 per day, per position, for each day after the 30 allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.
Excessive Reversals on Appeal	If the MCO exceeds 10% of member appeals overturned upon final appeal over a 12-month period (January-December or the first twelve months that the contract is in effect), a penalty of $25,000 may be imposed for every additional overturned appeal. This penalty may also be assessed for each occurrence in which the MCO does not provide the medical services or requirements set forth in an administrative decision by MLTC or a state fair hearing.
Ongoing and Ad Hoc Reporting	As detailed in Attachment 6, MLTC may assess a penalty of $1,000 for each calendar day that a report is late, inaccurate, includes less than the required copies, or is not in the approved format.

Encounter Data	$10,000 per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications required by MLTC. $10,000 per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the 5% error rate threshold, until acceptance of the data. $10,000 per return of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the 5% error rate threshold, for correction and was rejected for the second time. $10,000 per calendar day for inability to reconcile financial statement of medical expenses paid with the total dollars submitted through encounter data for that quarter within 10% for 2017 and 5% for 2018. $10,000 per occurrence of medical record review by MLTC or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.
Claims Processing	90% of all clean claims must be paid within 15 business days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. 99% of all clean claims must be paid within 60 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.
Pharmacy Claims Processing	90% of all clean claims must be paid within 7 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard. 99% of all clean claims must be paid within 14 calendar days of the date of receipt. If not met, subject to $5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.
PCP Assignment	$5,000 per calendar day for failure to assign a PCP within one month of the effective date of enrollment until the assignment is made.

Member Services	$5,000 per calendar day for failure to provide member services functions from 8 a.m. to 5 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.
Provider Services	$5,000 per calendar day for failure to furnish provider services functions from 7 a.m. to 8 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members and for failure to handle emergent provider issues on a 24 hours a day, 7 days a week basis.
Intermediate Sanctions	
Per 42 CFR 438.704(b)(1): A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; marketing violations.	
Per 42 CFR 438.704(b)(2): A maximum of $100,000 for each determination of discrimination; misrepresentation or false statements to CMS or the State or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(b)(3): A maximum of $15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above) or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(c): A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program; or any such action or inaction that the State deems a violation that merits a fine consistent with this section. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).	

Attachment 17
2015 Health Care Acquired Conditions

A HAC can be defied by a single diagnosis code, a combination of a diagnosis code and a surgical procedure, or a combination of a diagnosis code, a surgical procedure, and a principal diagnosis code.

CC: Complications and comorbidities
MCC: Major complications and comorbidities

Foreign Object Retained After Surgery		
(CC)	T81.509A	Unspecified complication of foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.519A	Adhesions due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.529A	Obstruction due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.539A	Perforation due to foreign body accidentally left in body following unspecified procedure, initial encounter
(CC)	T81.61XA	Aseptic peritonitis due to foreign substance accidentally left during a procedure, initial encounter
(CC)	T81.69XA	Other acute reaction to foreign substance accidentally left during a procedure, initial encounter
Air Embolism	T80.0XXA	Air embolism following infusion, transfusion and therapeutic injection, initial encounter
Blood Incompatibility		
(CC)	T80.30XA	ABO incompatibility reaction due to transfusion of blood or blood products, unspecified, initial encounter
(CC)	T80.319A	ABO incompatibility with hemolytic transfusion reaction, unspecified, initial encounter
(CC)	T80.310A	ABO incompatibility with acute hemolytic transfusion reaction, initial encounter
(CC)	T80.311A	ABO incompatibility with delayed hemolytic transfusion reaction, initial encounter
(CC)	T80.39XA	Other ABO incompatibility reaction due to transfusion of blood or blood products, initial encounter
Pressure Ulcer Stages III & IV		
(MCC)	L89003	Pressure ulcer of unspecified elbow, stage 3

(MCC)	L89004	Pressure ulcer of unspecified elbow, stage 4
(MCC)	L89013	Pressure ulcer of right elbow, stage 3
(MCC)	L89014	Pressure ulcer of right elbow, stage 4
(MCC)	L89023	Pressure ulcer of left elbow, stage 3
(MCC)	L89024	Pressure ulcer of left elbow, stage 4
(MCC)	L89103	Pressure ulcer of unspecified part of back, stage 3
(MCC)	L89104	Pressure ulcer of unspecified part of back, stage 4
(MCC)	L89113	Pressure ulcer of right upper back, stage 3
(MCC)	L89114	Pressure ulcer of right upper back, stage 4
(MCC)	L89123	Pressure ulcer of left upper back, stage 3
(MCC)	L89124	Pressure ulcer of left upper back, stage 4
(MCC)	L89133	Pressure ulcer of right lower back, stage 3
(MCC)	L89134	Pressure ulcer of right lower back, stage 4
(MCC)	L89143	Pressure ulcer of left lower back, stage 3
(MCC)	L89144	Pressure ulcer of left lower back, stage 4
(MCC)	L89153	Pressure ulcer of sacral region, stage 3
(MCC)	L89154	Pressure ulcer of sacral region, stage 4
(MCC)	L89203	Pressure ulcer of unspecified hip, stage 3
(MCC)	L89204	Pressure ulcer of unspecified hip, stage 4
(MCC)	L89213	Pressure ulcer of right hip, stage 3
(MCC)	L89214	Pressure ulcer of right hip, stage 4
(MCC)	L89223	Pressure ulcer of left hip, stage 3
(MCC)	L89224	Pressure ulcer of left hip, stage 4
(MCC)	L89303	Pressure ulcer of unspecified buttock, stage 3
(MCC)	L89304	Pressure ulcer of unspecified buttock, stage 4
(MCC)	L89313	Pressure ulcer of right buttock, stage 3
(MCC)	L89314	Pressure ulcer of right buttock, stage 4
(MCC)	L89323	Pressure ulcer of left buttock, stage 3
(MCC)	L89324	Pressure ulcer of left buttock, stage 4
(MCC)	L8943	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
(MCC)	L8944	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
(MCC)	L89503	Pressure ulcer of unspecified ankle, stage 3

(MCC)	L89504	Pressure ulcer of unspecified ankle, stage 4
(MCC)	L89513	Pressure ulcer of right ankle, stage 3
(MCC)	L89514	Pressure ulcer of right ankle, stage 4
(MCC)	L89523	Pressure ulcer of left ankle, stage 3
(MCC)	L89524	Pressure ulcer of left ankle, stage 4
(MCC)	L89603	Pressure ulcer of unspecified heel, stage 3
(MCC)	L89604	Pressure ulcer of unspecified heel, stage 4
(MCC)	L89613	Pressure ulcer of right heel, stage 3
(MCC)	L89614	Pressure ulcer of right heel, stage 4
(MCC)	L89623	Pressure ulcer of left heel, stage 3
(MCC)	L89624	Pressure ulcer of left heel, stage 4
(MCC)	L89813	Pressure ulcer of head, stage 3
(MCC)	L89814	Pressure ulcer of head, stage 4
(MCC)	L89893	Pressure ulcer of other site, stage 3
(MCC)	L89894	Pressure ulcer of other site, stage 4
(MCC)	L8993	Pressure ulcer of unspecified site, stage 3
(MCC)	L8994	Pressure ulcer of unspecified site, stage 4

Falls and Trauma:

Codes within these ranges on the CC/MCC list:

Fracture	S02.0XXA - T14.8
Dislocation	S03.0XXA - T14.90
Intracranial Injury	S06.0X0A - (S06.890A or S06.899A or S01.90XA)
Crushing Injury	(S07.0XXA or S07.8XXA) - S77.20XA
Burn	T26.50XA - (T30.0 or T30.4)
Other Injuries	(T33.09XA or T34.09XA) - (T73.8XXA or T73.9XXA or T75.89XA)

Catheter-Associated Urinary Tract Infection (UTI)

(CC)	T83.51XA	Infection and inflammatory reaction due to indwelling urinary catheter, initial encounter

Also excludes the following from acting as a CC/MCC:

(CC)	B37.42	Candidal balanitis
(CC)	B37.49	Other urogenital candidiasis

(CC)	N10	Acute tubulo-interstitial nephritis
(MCC)	N10	Acute tubulo-interstitial nephritis
(MCC)	N15.1	Renal and perinephric abscess
(CC)	N28.84	Pyelitis cystica
(CC)	N28.85	Pyeloureteritis cystica
(CC)	N28.86	Ureteritis cystica
(CC)	N12	Tubulo-interstitial nephritis, not specified as acute or chronic
(CC)	N16	Renal tubulo-interstitial disorders in diseases classified elsewhere
(CC)	N30.00	Acute cystitis without hematuria
(CC)	N30.01	Acute cystitis with hematuria
(CC)	N34.0	Urethral abscess
(CC)	N39.0	Urinary tract infection, site not specified
Vascular Catheter-Associated Infection		
(CC)	T80.219A	Unspecified infection due to central venous catheter, initial encounter
(CC)	T80.211A	Bloodstream infection due to central venous catheter, initial encounter
(CC)	T80.212A	Local infection due to central venous catheter, initial encounter
Manifestations of Poor Glycemic Control		
(MCC)	E11.69	Type 2 diabetes mellitus with other specified complication
(MCC)	E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
(MCC)	E11.69	Type 2 diabetes mellitus with other specified complication
(MCC)	E11.65	Type 2 diabetes mellitus with hyperglycemia
(MCC)	E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
(MCC)	E10.65	Type 1 diabetes mellitus with hyperglycemia
(MCC)	E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
(MCC)	E10.69	Type 1 diabetes mellitus with other specified complication
(MCC)	E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E11.65	Type 2 diabetes mellitus with hyperglycemia
(MCC)	E10.69	Type 1 diabetes mellitus with other specified complication
(MCC)	E10.65	Type 1 diabetes mellitus with hyperglycemia
(CC)	E15	Nondiabetic hypoglycemic coma

(MCC)	E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
(MCC)	E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
(MCC)	E13.10	Other specified diabetes mellitus with ketoacidosis without coma
(MCC)	E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
(MCC)	E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma with
(MCC)	E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
(MCC)	E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
(MCC)	E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
(MCC)	E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
(MCC)	E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
(MCC)	E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma with
(MCC)	E08.65	Diabetes mellitus due to underlying condition with hyperglycemia

Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)

(MCC)	J98.5	Diseases of mediastinum, not elsewhere classified

And one of the following procedure codes:

0210093	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach
02100A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Open Approach
02100J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Open Approach
02100K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Open Approach
02100Z3	Bypass Coronary Artery, One Site from Coronary Artery, Open Approach
0210493	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach

02104A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z3	Bypass Coronary Artery, One Site from Coronary Artery, Percutaneous Endoscopic Approach
021009W	Bypass Coronary Artery, One Site from Aorta with Autologous Venous Tissue, Open Approach
02100AW	Bypass Coronary Artery, One Site from Aorta with Autologous Arterial Tissue, Open Approach
02100JW	Bypass Coronary Artery, One Site from Aorta with Synthetic Substitute, Open Approach
02100KW	Bypass Coronary Artery, One Site from Aorta with Nonautologous Tissue Substitute, Open Approach
021049W	Bypass Coronary Artery, One Site from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104AW	Bypass Coronary Artery, One Site from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104JW	Bypass Coronary Artery, One Site from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02104KW	Bypass Coronary Artery, One Site from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021109W	Bypass Coronary Artery, Two Sites from Aorta with Autologous Venous Tissue, Open Approach
02110AW	Bypass Coronary Artery, Two Sites from Aorta with Autologous Arterial Tissue, Open Approach
02110JW	Bypass Coronary Artery, Two Sites from Aorta with Synthetic Substitute, Open Approach
02110KW	Bypass Coronary Artery, Two Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021149W	Bypass Coronary Artery, Two Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02114AW	Bypass Coronary Artery, Two Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114JW	Bypass Coronary Artery, Two Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach

02114KW	Bypass Coronary Artery, Two Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021209W	Bypass Coronary Artery, Three Sites from Aorta with Autologous Venous Tissue, Open Approach
02120AW	Bypass Coronary Artery, Three Sites from Aorta with Autologous Arterial Tissue, Open Approach
02120JW	Bypass Coronary Artery, Three Sites from Aorta with Synthetic Substitute, Open Approach
02120KW	Bypass Coronary Artery, Three Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021249W	Bypass Coronary Artery, Three Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02124AW	Bypass Coronary Artery, Three Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02124JW	Bypass Coronary Artery, Three Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02124KW	Bypass Coronary Artery, Three Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
021309W	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Venous Tissue, Open Approach
02130AW	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Arterial Tissue, Open Approach
02130JW	Bypass Coronary Artery, Four or More Sites from Aorta with Synthetic Substitute, Open Approach
02130KW	Bypass Coronary Artery, Four or More Sites from Aorta with Nonautologous Tissue Substitute, Open Approach
021349W	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02134AW	Bypass Coronary Artery, Four or More Sites from Aorta with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02134JW	Bypass Coronary Artery, Four or More Sites from Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach
02134KW	Bypass Coronary Artery, Four or More Sites from Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0210098	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Open Approach
0210099	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Open Approach

021009C	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Venous Tissue, Open Approach
02100A8	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Arterial Tissue, Open Approach
02100A9	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Arterial Tissue, Open Approach
02100AC	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02100J8	Bypass Coronary Artery, One Site from Right Internal Mammary with Synthetic Substitute, Open Approach
02100J9	Bypass Coronary Artery, One Site from Left Internal Mammary with Synthetic Substitute, Open Approach
02100JC	Bypass Coronary Artery, One Site from Thoracic Artery with Synthetic Substitute, Open Approach
02100K8	Bypass Coronary Artery, One Site from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02100K9	Bypass Coronary Artery, One Site from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02100KC	Bypass Coronary Artery, One Site from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02100Z8	Bypass Coronary Artery, One Site from Right Internal Mammary, Open Approach
02100Z9	Bypass Coronary Artery, One Site from Left Internal Mammary, Open Approach
02100ZC	Bypass Coronary Artery, One Site from Thoracic Artery, Open Approach
0210498	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
0210499	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
021049C	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104A8	Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104A9	Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104AC	Bypass Coronary Artery, One Site from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J8	Bypass Coronary Artery, One Site from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach

02104J9	Bypass Coronary Artery, One Site from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02104JC	Bypass Coronary Artery, One Site from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K8	Bypass Coronary Artery, One Site from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104K9	Bypass Coronary Artery, One Site from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104KC	Bypass Coronary Artery, One Site from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z8	Bypass Coronary Artery, One Site from Right Internal Mammary, Percutaneous Endoscopic Approach
02104Z9	Bypass Coronary Artery, One Site from Left Internal Mammary, Percutaneous Endoscopic Approach
02104ZC	Bypass Coronary Artery, One Site from Thoracic Artery, Percutaneous Endoscopic Approach
0211098	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach
0211099	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach
021109C	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach
02110A8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Arterial Tissue, Open Approach
02110A9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Arterial Tissue, Open Approach
02110AC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02110J8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Synthetic Substitute, Open Approach
02110J9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Synthetic Substitute, Open Approach
02110JC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02110K8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Nonautologous Tissue Substitute, Open Approach
02110K9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Nonautologous Tissue Substitute, Open Approach

02110KC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02110Z8	Bypass Coronary Artery, Two Sites from Right Internal Mammary, Open Approach
02110Z9	Bypass Coronary Artery, Two Sites from Left Internal Mammary, Open Approach
02110ZC	Bypass Coronary Artery, Two Sites from Thoracic Artery, Open Approach
0211498	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
0211499	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Percutaneous Endoscopic Approach
021149C	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02114A8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114A9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114AC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02114J8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02114J9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Synthetic Substitute, Percutaneous Endoscopic Approach
02114JC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02114K8	Bypass Coronary Artery, Two Sites from Right Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114K9	Bypass Coronary Artery, Two Sites from Left Internal Mammary with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114KC	Bypass Coronary Artery, Two Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02114Z8	Bypass Coronary Artery, Two Sites from Right Internal Mammary, Percutaneous Endoscopic Approach
02114Z9	Bypass Coronary Artery, Two Sites from Left Internal Mammary, Percutaneous Endoscopic Approach
02114ZC	Bypass Coronary Artery, Two Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021209C	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach

02120AC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02120JC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02120KC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02120ZC	Bypass Coronary Artery, Three Sites from Thoracic Artery, Open Approach
021249C	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02124AC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02124JC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02124KC	Bypass Coronary Artery, Three Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02124ZC	Bypass Coronary Artery, Three Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021309C	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Venous Tissue, Open Approach
02130AC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Arterial Tissue, Open Approach
02130JC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Synthetic Substitute, Open Approach
02130KC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Nonautologous Tissue Substitute, Open Approach
02130ZC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery, Open Approach
021349C	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02134AC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02134JC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02134KC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02134ZC	Bypass Coronary Artery, Four or More Sites from Thoracic Artery, Percutaneous Endoscopic Approach
021009F	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Venous Tissue, Open Approach

02100AF	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Arterial Tissue, Open Approach
02100JF	Bypass Coronary Artery, One Site from Abdominal Artery with Synthetic Substitute, Open Approach
02100KF	Bypass Coronary Artery, One Site from Abdominal Artery with Nonautologous Tissue Substitute, Open Approach
02100ZF	Bypass Coronary Artery, One Site from Abdominal Artery, Open Approach
021049F	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104AF	Bypass Coronary Artery, One Site from Abdominal Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104JF	Bypass Coronary Artery, One Site from Abdominal Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104KF	Bypass Coronary Artery, One Site from Abdominal Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104ZF	Bypass Coronary Artery, One Site from Abdominal Artery, Percutaneous Endoscopic Approach
0210093	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach
02100A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Open Approach
02100J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Open Approach
02100K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Open Approach
02100Z3	Bypass Coronary Artery, One Site from Coronary Artery, Open Approach
0210493	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Percutaneous Endoscopic Approach
02104A3	Bypass Coronary Artery, One Site from Coronary Artery with Autologous Arterial Tissue, Percutaneous Endoscopic Approach
02104J3	Bypass Coronary Artery, One Site from Coronary Artery with Synthetic Substitute, Percutaneous Endoscopic Approach
02104K3	Bypass Coronary Artery, One Site from Coronary Artery with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
02104Z3	Bypass Coronary Artery, One Site from Coronary Artery, Percutaneous Endoscopic Approach

Surgical Site Infection Following Certain Orthopedic Procedures

(CC)	T84.60XA	Infection and inflammatory reaction due to internal fixation device of unspecified site, initial encounter
(CC)	T84.7XXA	Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0RG0070	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG0071	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG007J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Open Approach
0RG00Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Open Approach
0RG00ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Open Approach
0RG0370	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG0371	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG037J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0RG03J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0RG0470	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG0471	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG047J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0RG04Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1070	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG1370	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG1470	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG4070	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG4370	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach

0RG43J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG4470	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1071	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG1371	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG1471	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0RG4071	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG4371	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG4471	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG6070	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG6370	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach

0RG63Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG6470	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA070	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RGA370	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA470	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG6071	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach

0RG60K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG6371	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG6471	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA071	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RGA371	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA471	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0RGA4J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG0070	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0SG0370	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG0470	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG3070	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Open Approach

0SG3370	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG3470	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG0071	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0SG0371	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG0471	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach

0SG04Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG3071	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Open Approach
0SG3371	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG3471	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG007J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Open Approach
0SG037J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0SG03KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG047J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG307J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Open Approach
0SG337J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG347J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG704Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Open Approach
0SG707Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Open Approach
0SG70JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Open Approach

0SG70KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Open Approach
0SG70ZZ	Fusion of Right Sacroiliac Joint, Open Approach
0SG734Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Percutaneous Approach
0SG737Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Approach
0SG73JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Percutaneous Approach
0SG73KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SG73ZZ	Fusion of Right Sacroiliac Joint, Percutaneous Approach
0SG744Z	Fusion of Right Sacroiliac Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0SG747Z	Fusion of Right Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG74JZ	Fusion of Right Sacroiliac Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SG74KZ	Fusion of Right Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG74ZZ	Fusion of Right Sacroiliac Joint, Percutaneous Endoscopic Approach
0SG804Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Open Approach
0SG807Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Open Approach
0SG80JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Open Approach
0SG80KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Open Approach
0SG80ZZ	Fusion of Left Sacroiliac Joint, Open Approach
0SG834Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Percutaneous Approach
0SG837Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Approach
0SG83JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Percutaneous Approach
0SG83KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0SG83ZZ	Fusion of Left Sacroiliac Joint, Percutaneous Approach
0SG844Z	Fusion of Left Sacroiliac Joint with Internal Fixation Device, Percutaneous Endoscopic Approach

0SG847Z	Fusion of Left Sacroiliac Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG84JZ	Fusion of Left Sacroiliac Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0SG84KZ	Fusion of Left Sacroiliac Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0SG84ZZ	Fusion of Left Sacroiliac Joint, Percutaneous Endoscopic Approach
0RGJ04Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Open Approach
0RGJ07Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGJ0JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Open Approach
0RGJ0KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGJ0ZZ	Fusion of Right Shoulder Joint, Open Approach
0RGJ34Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGJ37Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGJ3JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGJ3KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGJ3ZZ	Fusion of Right Shoulder Joint, Percutaneous Approach
0RGJ44Z	Fusion of Right Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGJ47Z	Fusion of Right Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4JZ	Fusion of Right Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGJ4KZ	Fusion of Right Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGJ4ZZ	Fusion of Right Shoulder Joint, Percutaneous Endoscopic Approach
0RGK04Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Open Approach
0RGK07Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Open Approach
0RGK0JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Open Approach
0RGK0KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Open Approach
0RGK0ZZ	Fusion of Left Shoulder Joint, Open Approach

0RGK34Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Approach
0RGK37Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGK3JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Approach
0RGK3KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGK3ZZ	Fusion of Left Shoulder Joint, Percutaneous Approach
0RGK44Z	Fusion of Left Shoulder Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGK47Z	Fusion of Left Shoulder Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK4JZ	Fusion of Left Shoulder Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGK4KZ	Fusion of Left Shoulder Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGK4ZZ	Fusion of Left Shoulder Joint, Percutaneous Endoscopic Approach
0RGL04Z	Fusion of Right Elbow Joint with Internal Fixation Device, Open Approach
0RGL05Z	Fusion of Right Elbow Joint with External Fixation Device, Open Approach
0RGL07Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Open Approach
0RGL0JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Open Approach
0RGL0KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RGL0ZZ	Fusion of Right Elbow Joint, Open Approach
0RGL34Z	Fusion of Right Elbow Joint with Internal Fixation Device, Percutaneous Approach
0RGL35Z	Fusion of Right Elbow Joint with External Fixation Device, Percutaneous Approach
0RGL37Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGL3JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Percutaneous Approach
0RGL3KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGL3ZZ	Fusion of Right Elbow Joint, Percutaneous Approach
0RGL44Z	Fusion of Right Elbow Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGL45Z	Fusion of Right Elbow Joint with External Fixation Device, Percutaneous Endoscopic Approach

0RGL47Z	Fusion of Right Elbow Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGL4JZ	Fusion of Right Elbow Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGL4KZ	Fusion of Right Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGL4ZZ	Fusion of Right Elbow Joint, Percutaneous Endoscopic Approach
0RGM04Z	Fusion of Left Elbow Joint with Internal Fixation Device, Open Approach
0RGM05Z	Fusion of Left Elbow Joint with External Fixation Device, Open Approach
0RGM07Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Open Approach
0RGM0JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Open Approach
0RGM0KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Open Approach
0RGM0ZZ	Fusion of Left Elbow Joint, Open Approach
0RGM34Z	Fusion of Left Elbow Joint with Internal Fixation Device, Percutaneous Approach
0RGM35Z	Fusion of Left Elbow Joint with External Fixation Device, Percutaneous Approach
0RGM37Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Percutaneous Approach
0RGM3JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Percutaneous Approach
0RGM3KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Approach
0RGM3ZZ	Fusion of Left Elbow Joint, Percutaneous Approach
0RGM44Z	Fusion of Left Elbow Joint with Internal Fixation Device, Percutaneous Endoscopic Approach
0RGM45Z	Fusion of Left Elbow Joint with External Fixation Device, Percutaneous Endoscopic Approach
0RGM47Z	Fusion of Left Elbow Joint with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGM4JZ	Fusion of Left Elbow Joint with Synthetic Substitute, Percutaneous Endoscopic Approach
0RGM4KZ	Fusion of Left Elbow Joint with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0RGM4ZZ	Fusion of Left Elbow Joint, Percutaneous Endoscopic Approach
0RG0070	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG0071	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach

0RG007J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG00K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG00KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0RG00Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Open Approach
0RG00Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Open Approach
0RG00ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Open Approach
0RG0370	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG0371	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG037J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0RG03K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach

0RG03Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG03Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG03ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0RG0470	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG0471	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG047J	Fusion of Occipital-cervical Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J0	Fusion of Occipital-cervical Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04J1	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04JJ	Fusion of Occipital-cervical Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K0	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04K1	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04KJ	Fusion of Occipital-cervical Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z0	Fusion of Occipital-cervical Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG04Z1	Fusion of Occipital-cervical Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG04ZJ	Fusion of Occipital-cervical Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1070	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG10Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Open Approach

0RG1370	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG13Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG1470	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14J0	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14K0	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG14Z0	Fusion of Cervical Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG4070	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG40Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG4370	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG43Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG4470	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44J0	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG44K0	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0RG44Z0	Fusion of Cervicothoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG1071	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG10Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG1371	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG13Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG1471	Fusion of Cervical Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14J1	Fusion of Cervical Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14K1	Fusion of Cervical Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG14Z1	Fusion of Cervical Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG4071	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG40Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG4371	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach

0RG43K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG43Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RG4471	Fusion of Cervicothoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44J1	Fusion of Cervicothoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44K1	Fusion of Cervicothoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG44Z1	Fusion of Cervicothoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG6070	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RG60Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RG6370	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RG63Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RG6470	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64J0	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64K0	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG64Z0	Fusion of Thoracic Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA070	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach

0RGA0J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0RGA0Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0RGA370	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA3Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0RGA470	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4J0	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4K0	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RGA4Z0	Fusion of Thoracolumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RG6071	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RG60Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RG6371	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RG63Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach

0RG6471	Fusion of Thoracic Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64J1	Fusion of Thoracic Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64K1	Fusion of Thoracic Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RG64Z1	Fusion of Thoracic Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA071	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0RGA0Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0RGA371	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA3Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0RGA471	Fusion of Thoracolumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4J1	Fusion of Thoracolumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4K1	Fusion of Thoracolumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0RGA4Z1	Fusion of Thoracolumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG0070	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG00K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach

0SG00Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Open Approach
0SG0370	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG03Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG0470	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04J0	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04K0	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04Z0	Fusion of Lumbar Vertebral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG3070	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Open Approach
0SG30Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Open Approach
0SG3370	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Approach
0SG33Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Approach
0SG3470	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34J0	Fusion of Lumbosacral Joint with Synthetic Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0SG34K0	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34Z0	Fusion of Lumbosacral Joint, Anterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG0071	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG00Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Open Approach
0SG0371	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG03Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG0471	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04J1	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04K1	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG04Z1	Fusion of Lumbar Vertebral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG3071	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach
0SG30Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Open Approach
0SG3371	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach

0SG33J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Approach
0SG33Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Approach
0SG3471	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34J1	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34K1	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG34Z1	Fusion of Lumbosacral Joint, Posterior Approach, Posterior Column, Percutaneous Endoscopic Approach
0SG007J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG00ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Open Approach
0SG037J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG03ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG047J	Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04JJ	Fusion of Lumbar Vertebral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04KJ	Fusion of Lumbar Vertebral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG04ZJ	Fusion of Lumbar Vertebral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach

0SG307J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Open Approach
0SG30ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Open Approach
0SG337J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Approach
0SG33ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Approach
0SG347J	Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34JJ	Fusion of Lumbosacral Joint with Synthetic Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34KJ	Fusion of Lumbosacral Joint with Nonautologous Tissue Substitute, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0SG34ZJ	Fusion of Lumbosacral Joint, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach
0RQE0ZZ	Repair Right Sternoclavicular Joint, Open Approach
0RQE3ZZ	Repair Right Sternoclavicular Joint, Percutaneous Approach
0RQE4ZZ	Repair Right Sternoclavicular Joint, Percutaneous Endoscopic Approach
0RQEXZZ	Repair Right Sternoclavicular Joint, External Approach
0RQF0ZZ	Repair Left Sternoclavicular Joint, Open Approach
0RQF3ZZ	Repair Left Sternoclavicular Joint, Percutaneous Approach
0RQF4ZZ	Repair Left Sternoclavicular Joint, Percutaneous Endoscopic Approach
0RQFXZZ	Repair Left Sternoclavicular Joint, External Approach
0RQG0ZZ	Repair Right Acromioclavicular Joint, Open Approach
0RQG3ZZ	Repair Right Acromioclavicular Joint, Percutaneous Approach
0RQG4ZZ	Repair Right Acromioclavicular Joint, Percutaneous Endoscopic Approach
0RQGXZZ	Repair Right Acromioclavicular Joint, External Approach
0RQH0ZZ	Repair Left Acromioclavicular Joint, Open Approach

	0RQH3ZZ	Repair Left Acromioclavicular Joint, Percutaneous Approach
	0RQH4ZZ	Repair Left Acromioclavicular Joint, Percutaneous Endoscopic Approach
	0RQHXZZ	Repair Left Acromioclavicular Joint, External Approach
	0RQJ0ZZ	Repair Right Shoulder Joint, Open Approach
	0RQJ3ZZ	Repair Right Shoulder Joint, Percutaneous Approach
	0RQJ4ZZ	Repair Right Shoulder Joint, Percutaneous Endoscopic Approach
	0RQJXZZ	Repair Right Shoulder Joint, External Approach
	0RQK0ZZ	Repair Left Shoulder Joint, Open Approach
	0RQK3ZZ	Repair Left Shoulder Joint, Percutaneous Approach
	0RQK4ZZ	Repair Left Shoulder Joint, Percutaneous Endoscopic Approach
	0RQKXZZ	Repair Left Shoulder Joint, External Approach
	0RQL0ZZ	Repair Right Elbow Joint, Open Approach
	0RQL3ZZ	Repair Right Elbow Joint, Percutaneous Approach
	0RQL4ZZ	Repair Right Elbow Joint, Percutaneous Endoscopic Approach
	0RQLXZZ	Repair Right Elbow Joint, External Approach
	0RQM0ZZ	Repair Left Elbow Joint, Open Approach
	0RQM3ZZ	Repair Left Elbow Joint, Percutaneous Approach
	0RQM4ZZ	Repair Left Elbow Joint, Percutaneous Endoscopic Approach
	0RQMXZZ	Repair Left Elbow Joint, External Approach

Surgical Site Infection Following Bariatric Surgery for Obesity

Principal Diagnosis	E66.01	Morbid (severe) obesity due to excess calories
(CC)	K95.01	Infection due to gastric band procedure
(CC)	K95.81	Infection due to other bariatric procedure
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0D16479	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164J9	Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach

0D164JA	Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164Z9	Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D16079	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach
0D1607A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach
0D160J9	Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach
0D160JA	Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach
0D160K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D160KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D160Z9	Bypass Stomach to Duodenum, Open Approach
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D16879	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168J9	Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JA	Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168Z9	Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic
0D168ZA	Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach

Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

(CC)	T82.6XXA	Infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter
(CC)	T82.7XXA	Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, initial encounter
(CC)	K68.11	Postprocedural retroperitoneal abscess
(CC)	T81.4XXA	Infection following a procedure, initial encounter

And one of the following procedure codes:

0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH807Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH837Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
02HK0JZ	Insertion of Pacemaker Lead into Right Ventricle, Open Approach
02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
02HK4JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0JZ	Insertion of Pacemaker Lead into Left Ventricle, Open Approach
02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
02HL4JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Endoscopic Approach
With:	02H40JZ Insertion of Pacemaker Lead into Coronary Vein, Open Approach
02H43JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Approach
02H44JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Endoscopic Approach
With:	02H60JZ Insertion of Pacemaker Lead into Right Atrium, Open Approach
02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
02H64JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Endoscopic Approach
0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

0JH809Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH839Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	02HK0KZ Insertion of Defibrillator Lead into Right Ventricle, Open Approach
02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
02H43JZ	Insertion of Pacemaker Lead into Coronary Vein, Percutaneous Approach
02H43KZ	Insertion of Defibrillator Lead into Coronary Vein, Percutaneous Approach
02H43MZ	Insertion of Cardiac Lead into Coronary Vein, Percutaneous Approach
Alternatively:	
02H43KZ	Insertion of Defibrillator Lead into Coronary Vein, Percutaneous Approach
02H43MZ	Insertion of Cardiac Lead into Coronary Vein, Percutaneous Approach
With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH807Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH837Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:	
0JH607Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH637Z	Insertion of Cardiac Resynchronization Pacemaker Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

	With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH809Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH839Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:		
	0JH609Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH639Z	Insertion of Cardiac Resynchronization Defibrillator Pulse Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH60PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Alternatively:		
	0JH60PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63PZ	Insertion of Cardiac Rhythm Related Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83PZ	Insertion of Cardiac Rhythm Related Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach

With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH604Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH634Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH804Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH834Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH605Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH635Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH805Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH835Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH606Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH636Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH806Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH836Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH604Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH634Z	Insertion of Pacemaker, Single Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH804Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH834Z	Insertion of Pacemaker, Single Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach

0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH605Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH635Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH805Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH835Z	Insertion of Pacemaker, Single Chamber Rate Responsive into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH606Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH636Z	Insertion of Pacemaker, Dual Chamber into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH806Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH836Z	Insertion of Pacemaker, Dual Chamber into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach

With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
With:	02H60KZ Insertion of Defibrillator Lead into Right Atrium, Open Approach
02H63KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Approach
02H64KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Endoscopic Approach
02H70KZ	Insertion of Defibrillator Lead into Left Atrium, Open Approach
02H73KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Approach
02H74KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Endoscopic Approach
02HK0KZ	Insertion of Defibrillator Lead into Right Ventricle, Open Approach
02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	02H60KZ Insertion of Defibrillator Lead into Right Atrium, Open Approach
02H63KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Approach
02H64KZ	Insertion of Defibrillator Lead into Right Atrium, Percutaneous Endoscopic Approach
02H70KZ	Insertion of Defibrillator Lead into Left Atrium, Open Approach
02H73KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Approach
02H74KZ	Insertion of Defibrillator Lead into Left Atrium, Percutaneous Endoscopic Approach
02HK0KZ	Insertion of Defibrillator Lead into Right Ventricle, Open Approach

02HK3KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Approach
02HK4KZ	Insertion of Defibrillator Lead into Right Ventricle, Percutaneous Endoscopic Approach
02HL0KZ	Insertion of Defibrillator Lead into Left Ventricle, Open Approach
02HL3KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Approach
02HL4KZ	Insertion of Defibrillator Lead into Left Ventricle, Percutaneous Endoscopic Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH608Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH638Z	Insertion of Defibrillator Generator into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH808Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH838Z	Insertion of Defibrillator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
With:	0JPT0PZ Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
02HN0JZ	Insertion of Pacemaker Lead into Pericardium, Open Approach
02HN0MZ	Insertion of Cardiac Lead into Pericardium, Open Approach
02HN3JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Approach
02HN3MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Approach
02HN4JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Endoscopic Approach
02HN4MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Endoscopic Approach

Alternatively:

02HN0JZ	Insertion of Pacemaker Lead into Pericardium, Open Approach
02HN0MZ	Insertion of Cardiac Lead into Pericardium, Open Approach

	02HN3JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Approach
	02HN3MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Approach
	02HN4JZ	Insertion of Pacemaker Lead into Pericardium, Percutaneous Endoscopic Approach
	02HN4MZ	Insertion of Cardiac Lead into Pericardium, Percutaneous Endoscopic Approach
	With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
	02WA0MZ	Revision of Cardiac Lead in Heart, Open Approach
	02WA3MZ	Revision of Cardiac Lead in Heart, Percutaneous Approach
	02WA4MZ	Revision of Cardiac Lead in Heart, Percutaneous Endoscopic Approach
	02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
	02H63MZ	Insertion of Cardiac Lead into Right Atrium, Percutaneous Approach
	02H73JZ	Insertion of Pacemaker Lead into Left Atrium, Percutaneous Approach
	02H73MZ	Insertion of Cardiac Lead into Left Atrium, Percutaneous Approach
	02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
	02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
Alternatively:		
	02H63JZ	Insertion of Pacemaker Lead into Right Atrium, Percutaneous Approach
	02H73JZ	Insertion of Pacemaker Lead into Left Atrium, Percutaneous Approach
	02HK3JZ	Insertion of Pacemaker Lead into Right Ventricle, Percutaneous Approach
	02HK3MZ	Insertion of Cardiac Lead into Right Ventricle, Percutaneous Approach
	02HL3JZ	Insertion of Pacemaker Lead into Left Ventricle, Percutaneous Approach
	02HL3MZ	Insertion of Cardiac Lead into Left Ventricle, Percutaneous Approach
	With:	02PA0MZ Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach
	02PA0MZ	Removal of Cardiac Lead from Heart, Open Approach
	02PA3MZ	Removal of Cardiac Lead from Heart, Percutaneous Approach
	02PA4MZ	Removal of Cardiac Lead from Heart, Percutaneous Endoscopic Approach
	02PAXMZ	Removal of Cardiac Lead from Heart, External Approach

	0JWT0PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JWT3PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JPT0PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JPT3PZ	Removal of Cardiac Rhythm Related Device from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JWT0PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Open Approach
	0JWT3PZ	Revision of Cardiac Rhythm Related Device in Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures		
(MCC)	T80.0XXA	Air embolism following infusion, transfusion and therapeutic injection, initial encounter
(MCC)	T81.718A	Complication of other artery following a procedure, not elsewhere classified, initial encounter
(MCC)	T81.72XA	Complication of vein following a procedure, not elsewhere classified, initial encounter
(MCC)	T82.817A	Embolism of cardiac prosthetic devices, implants and grafts, initial encounter
(MCC)	T82.818A	Embolism of vascular prosthetic devices, implants and grafts, initial encounter
(MCC)	With:	I26.90 Septic pulmonary embolism without acute cor pulmonale
(MCC)	I26.99	Other pulmonary embolism without acute cor pulmonale
(MCC)	I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
(MCC)	I26.99	Other pulmonary embolism without acute cor pulmonale
(CC)	I82.409	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
(CC)	I82.419	Acute embolism and thrombosis of unspecified femoral vein
(CC)	I82.429	Acute embolism and thrombosis of unspecified iliac vein
(CC)	I82.439	Acute embolism and thrombosis of unspecified popliteal vein
(CC)	I82.4Y9	Acute embolism and thrombosis of unspecified deep veins of unspecified proximal lower extremity
(CC)	I82.449	Acute embolism and thrombosis of unspecified tibial vein
(CC)	I82.499	Acute embolism and thrombosis of other specified deep vein of unspecified lower extremity

(CC)	I82.4Z9	Acute embolism and thrombosis of unspecified deep veins of unspecified distal lower extremity

And one of the following procedure codes:

0SUR0BZ	Supplement Right Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
With:	0SUA0BZ Supplement Right Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUS0BZ	Supplement Left Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
With:	0SUE0BZ Supplement Left Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUR0BZ	Supplement Right Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
0SUS0BZ	Supplement Left Hip Joint, Femoral Surface with Resurfacing Device, Open Approach
0SUA0BZ	Supplement Right Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SUE0BZ	Supplement Left Hip Joint, Acetabular Surface with Resurfacing Device, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRA009	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRA00A	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRA00Z	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRA019	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach

0SRA01A	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRA01Z	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRA039	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRA03A	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRA03Z	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRA07Z	Replacement of Right Hip Joint, Acetabular Surface with Autologous Tissue Substitute, Open Approach
0SRA0J9	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRA0JA	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRA0JZ	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRA0KZ	Replacement of Right Hip Joint, Acetabular Surface with Nonautologous Tissue Substitute, Open Approach
0SRE009	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRE00A	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRE00Z	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRE019	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRE01A	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRE01Z	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRE039	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRE03A	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRE03Z	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach

0SRE07Z	Replacement of Left Hip Joint, Acetabular Surface with Autologous Tissue Substitute, Open Approach
0SRE0J9	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRE0JA	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRE0JZ	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRE0KZ	Replacement of Left Hip Joint, Acetabular Surface with Nonautologous Tissue Substitute, Open Approach
0SRR019	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRR01A	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRR01Z	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach
0SRR039	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRR03A	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRR03Z	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRR07Z	Replacement of Right Hip Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRR0J9	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRR0JA	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRR0JZ	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRR0KZ	Replacement of Right Hip Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRS019	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRS01A	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRS01Z	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach

0SRS039	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRS03A	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRS03Z	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRS07Z	Replacement of Left Hip Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRS0J9	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRS0JA	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRS0JZ	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRS0KZ	Replacement of Left Hip Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRC07Z	Replacement of Right Knee Joint with Autologous Tissue Substitute, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRC0KZ	Replacement of Right Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRD07Z	Replacement of Left Knee Joint with Autologous Tissue Substitute, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRD0KZ	Replacement of Left Knee Joint with Nonautologous Tissue Substitute, Open Approach
0SRT07Z	Replacement of Right Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRT0JZ	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRT0KZ	Replacement of Right Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach
0SRU07Z	Replacement of Left Knee Joint, Femoral Surface with Autologous Tissue Substitute, Open Approach
0SRU0JZ	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRU0KZ	Replacement of Left Knee Joint, Femoral Surface with Nonautologous Tissue Substitute, Open Approach

	0SRV07Z	Replacement of Right Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
	0SRV0JZ	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
	0SRV0KZ	Replacement of Right Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
	0SRW07Z	Replacement of Left Knee Joint, Tibial Surface with Autologous Tissue Substitute, Open Approach
	0SRW0JZ	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
	0SRW0KZ	Replacement of Left Knee Joint, Tibial Surface with Nonautologous Tissue Substitute, Open Approach
Iatrogenic Pneumothorax with Venous Catheterization		
(CC)	J95.811	Postprocedural pneumothorax
	05HY03Z	Insertion of Infusion Device into Upper Vein, Open Approach
	05HY33Z	Insertion of Infusion Device into Upper Vein, Percutaneous Approach
	05HY43Z	Insertion of Infusion Device into Upper Vein, Percutaneous Endoscopic Approach
	06HY03Z	Insertion of Infusion Device into Lower Vein, Open Approach
	06HY33Z	Insertion of Infusion Device into Lower Vein, Percutaneous Approach
	06HY43Z	Insertion of Infusion Device into Lower Vein, Percutaneous Endoscopic Approach
	0JH60XZ	Insertion of Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Open Approach
	0JH63XZ	Insertion of Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JH80XZ	Insertion of Vascular Access Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
	0JH83XZ	Insertion of Vascular Access Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JHD0XZ	Insertion of Vascular Access Device into Right Upper Arm Subcutaneous Tissue and Fascia, Open Approach
	0JHD3XZ	Insertion of Vascular Access Device into Right Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
	0JHF0XZ	Insertion of Vascular Access Device into Left Upper Arm Subcutaneous Tissue and Fascia, Open Approach
	0JHF3XZ	Insertion of Vascular Access Device into Left Upper Arm Subcutaneous Tissue and Fascia, Percutaneous Approach

0JHG0XZ	Insertion of Vascular Access Device into Right Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JHG3XZ	Insertion of Vascular Access Device into Right Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHH0XZ	Insertion of Vascular Access Device into Left Lower Arm Subcutaneous Tissue and Fascia, Open Approach
0JHH3XZ	Insertion of Vascular Access Device into Left Lower Arm Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHL0XZ	Insertion of Vascular Access Device into Right Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JHL3XZ	Insertion of Vascular Access Device into Right Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHM0XZ	Insertion of Vascular Access Device into Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
0JHM3XZ	Insertion of Vascular Access Device into Left Upper Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHN0XZ	Insertion of Vascular Access Device into Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JHN3XZ	Insertion of Vascular Access Device into Right Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
0JHP0XZ	Insertion of Vascular Access Device into Left Lower Leg Subcutaneous Tissue and Fascia, Open Approach
0JHP3XZ	Insertion of Vascular Access Device into Left Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach

Exempt Providers

The table below lists the types of providers that are exempt from POA reporting, per CMS http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals.html.

1	Critical Access Hospitals	These providers have a Peer Group 7 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.
2	Long Term Care Hospitals	Nebraska has two providers that fall into this category. The providers will be added to the Validate Value table: 1. Select Specialty (100256413-00) 2. Madonna Rehabilitation (100251802-00)
3	Maryland Waiver Hospitals	State/Postal Code = MD **Note**: Maryland is the only State that has a Medicare Waiver. Under this agreement, Medicare reimburses Maryland hospitals according to Healthcare Services Cost Review Commission (HSCRC) rates. Based on a federal waiver from Medicare, the HSCRC sets rates for all payers: private insurance companies, HMOs, Medicare, and Medicaid. This system is referred to as the "all-payer" system because all payers pay for their fair share of hospital costs.
4	Cancer Hospitals	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
5	Children's Inpatient Facilities	The word 'child' will be queried in the provider names and the identified providers will be added to the Validate Value table.
6	Rural Health Clinics	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
7	Federally Qualified Health Centers	This provider type does not submit claim types 07 or 10 and therefore will be indirectly excluded from being required to submit POA information.
8	Religious Non-Medical Health Care Institutions	These providers would be added to the Validate Value table as they manually identify themselves. This would most likely occur because the MMIS reported they must submit POA and they respond advising they are POA exempt.
9	Inpatient Psychiatric Hospitals	These providers would be identified by Specialty = 26 and either included in the code as exempt providers or added to the Validate Value table.
10	Inpatient Rehabilitation Facilities	These providers have a Peer Group 5 in the MMIS and are therefore included in the group of providers that will be defined as exempt from POA reporting.

11	VA/Department of Defense Hospitals	These providers are paid from federal funds and do not submit claims to State Medicaid agencies.

Categories and Codes
Exempt from
Diagnosis Present on Admission Requirement
ICD-10-CM Official Guidelines for Coding and Reporting FY 2015

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

Code categories below are exempt from "diagnosis present on admission."

B90–B94, Sequelae of infectious and parasitic diseases

E64, Sequelae of malnutrition and other nutritional deficiencies

I25.2, Old myocardial infarction

I69, Sequelae of cerebrovascular disease

O09, Supervision of high risk pregnancy

O66.5, Attempted application of vacuum extractor and forceps

O80, Encounter for full-term uncomplicated delivery

O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

P00, Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy

Q00 – Q99, Congenital malformations, deformations and chromosomal abnormalities

S00-T88.9, Injury, poisoning and certain other consequences of external causes with 7th character representing subsequent encounter or sequela

V00- V09, Pedestrian injured in transport accident

Except V00.81-, Accident with wheelchair (powered)

V00.83-, Accident with motorized mobility scooter

V10-V19, Pedal cycle rider injured in transport accident

V20-V29, Motorcycle rider injured in transport accident

V30-V39, Occupant of three-wheeled motor vehicle injured in transport accident

V40-V49, Car occupant injured in transport accident

V50-V59, Occupant of pick-up truck or van injured in transport accident

V60-V69, Occupant of heavy transport vehicle injured in transport accident

V70-V79, Bus occupant injured in transport accident

V80-V89, Other land transport accidents

V90-V94, Water transport accidents

V95-V97, Air and space transport accidents

V98-V99, Other and unspecified transport accidents

W09, Fall on and from playground equipment

W14, Fall from tree

W15, Fall from cliff

W17.0, Fall into well

W17.1, Fall into storm drain or manhole

W18.01 Striking against sports equipment with subsequent fall

W21, Striking against or struck by sports equipment

W30, Contact with agricultural machinery

W31, Contact with other and unspecified machinery

W32-W34, Accidental handgun discharge and malfunction

W35- W40, Exposure to inanimate mechanical forces

W52, Crushed, pushed or stepped on by crowd or human stampede

W56, Contact with nonvenomous marine animal

W58, Contact with crocodile or alligator

W61, Contact with birds (domestic) (wild)

W62, Contact with nonvenomous amphibians

W89, Exposure to man-made visible and ultraviolet light

X02, Exposure to controlled fire in building or structure

X03, Exposure to controlled fire, not in building or structure

X04, Exposure to ignition of highly flammable material

X52, Prolonged stay in weightless environment

X71, Intentional self-harm by drowning and submersion

Except X71.0-, Intentional self-harm by drowning and submersion while in bath tub

X72, Intentional self-harm by handgun discharge

X73, Intentional self-harm by rifle, shotgun and larger firearm discharge

X74, Intentional self-harm by other and unspecified firearm and gun discharge

X75, Intentional self-harm by explosive material

X76, Intentional self-harm by smoke, fire and flames

X77, Intentional self-harm by steam, hot vapors and hot objects

X81, Intentional self-harm by jumping or lying in front of moving object

X82, Intentional self-harm by crashing of motor vehicle

X83, Intentional self-harm by other specified means

Y03, Assault by crashing of motor vehicle

Y07, Perpetrator of assault, maltreatment and neglect

Y08.8, Assault by strike by sports equipment

Y21, Drowning and submersion, undetermined intent

Y22, Handgun discharge, undetermined intent

Y23, Rifle, shotgun and larger firearm discharge, undetermined intent

Y24, Other and unspecified firearm discharge, undetermined intent

Y30, Falling, jumping or pushed from a high place, undetermined intent

Y32, Assault by crashing of motor vehicle, undetermined intent

Y37, Military operations

Y36, Operations of war

Y92, Place of occurrence of the external cause

Y93, Activity code

Y99, External cause status

Z00, Encounter for general examination without complaint, suspected or reported diagnosis

Z01, Encounter for other special examination without complaint, suspected or reported diagnosis

Z02, Encounter for administrative examination

Z03, Encounter for medical observation for suspected diseases and conditions ruled out

Z08, Encounter for follow-up examination following completed treatment for malignant neoplasm

Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z11, Encounter for screening for infectious and parasitic diseases

Z11.8, Encounter for screening for other infectious and parasitic diseases

Z12, Encounter for screening for malignant neoplasms

Z13, Encounter for screening for other diseases and disorders

Z13.4, Encounter for screening for certain developmental disorders in childhood

Z13.5, Encounter for screening for eye and ear disorders

Z13.6, Encounter for screening for cardiovascular disorders

Z13.83, Encounter for screening for respiratory disorder NEC

Z13.89, Encounter for screening for other disorder

Z13.89, Encounter for screening for other disorder

Z14, Genetic carrier

Z15, Genetic susceptibility to disease

Z17, Estrogen receptor status

Z18, Retained foreign body fragments

Z22, Carrier of infectious disease

Z23, Encounter for immunization

Z28, Immunization not carried out and underimmunization status

Z28.3, Underimmunization status

Z30, Encounter for contraceptive management

Z31, Encounter for procreative management

Z34, Encounter for supervision of normal pregnancy

Z36, Encounter for antenatal screening of mother

Z37, Outcome of delivery

Z38, Liveborn infants according to place of birth and type of delivery

Z39, Encounter for maternal postpartum care and examination

Z41, Encounter for procedures for purposes other than remedying health state

Z42, Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Z43, Encounter for attention to artificial openings

Z44, Encounter for fitting and adjustment of external prosthetic device

Z45, Encounter for adjustment and management of implanted device

Z46, Encounter for fitting and adjustment of other devices

Z47.8, Encounter for other orthopedic aftercare

Z49, Encounter for care involving renal dialysis

Z51, Encounter for other aftercare

Z51.5, Encounter for palliative care

Z51.8, Encounter for other specified aftercare

Z52, Donors of organs and tissues

Z59, Problems related to housing and economic circumstances

Z63, Other problems related to primary support group, including family circumstances

Z65, Problems related to other psychosocial circumstances

Z65.8 Other specified problems related to psychosocial circumstances

Z67.1 – Z67.9 Blood type

Z68, Body mass index (BMI)

Z72, Problems related to lifestyle

Z74.01, Bed confinement status

Z76, Persons encountering health services in other circumstances

Z77.110- Z77.128, Environmental pollution and hazards in the physical environment

Z78, Other specified health status

Z79, Long term (current) drug therapy

Z80, Family history of primary malignant neoplasm

Z81, Family history of mental and behavioral disorders

Z82, Family history of certain disabilities and chronic diseases (leading to disablement)

Z83, Family history of other specific disorders

Z84, Family history of other conditions

Z85, Personal history of primary malignant neoplasm

Z86, Personal history of certain other diseases

Z87, Personal history of other diseases and conditions

Z87.828, Personal history of other (healed) physical injury and trauma

Z87.891, Personal history of nicotine dependence

Z88, Allergy status to drugs, medicaments and biological substances

Z89, Acquired absence of limb

Z90.710, Acquired absence of both cervix and uterus

Z91.0, Allergy status, other than to drugs and biological substances

Z91.4, Personal history of psychological trauma, not elsewhere classified

Z91.5, Personal history of self-harm

Z91.8, Other specified risk factors, not elsewhere classified

Z92, Personal history of medical treatment

Z93, Artificial opening status

Z94, Transplanted organ and tissue status

Z95, Presence of cardiac and vascular implants and grafts

Z97, Presence of other devices

Z98, Other postprocedural states

Z99, Dependence on enabling machines and devices, not elsewhere classified

PROVIDER NUMBER		BUSINESS NAME	LINE 1 ADDRESS	LINE 2 ADDRESS	CITY NAME	POSTAL CODE	OFFICE ZIP CODE	
100252968	00	TILDEN COMMUNITY HOSPITAL	PO BOX 340		TILDEN	NE	68781	0340
100254997	00	OAKLAND MERCY HOSPITAL	601 EAST 2ND ST		OAKLAND	NE	68045	1499
100259444	00	AVERA CREIGHTON HOSPITAL	1503 MAIN ST	PO BOX 186	CREIGHTON	NE	68729	0186
100261871	00	ALEGENT CREIGHTON HLTH-PLAINVIEW HS	704 N 3RD ST		PLAINVIEW	NE	68769	2047
237161473	00	OSMOND GEN HOSP	402 NORTH MAPLE ST	PO BOX 429	OSMOND	NE	68765	0429
363169688	00	PAWNEE CO MEM HOSP	600 I ST	PO BOX 433	PAWNEE CITY	NE	68420	0433
456029692	00	LEXINGTON REGIONAL HEALTH CENTER	1201 ERIE	PO BOX 980	LEXINGTON	NE	68850	1571
470366569	00	HENDERSON HEALTH CARE SERVICES,INC	1621 FRONT ST		HENDERSON	NE	68371	8902
470375220	00	MEM HOSP-SEWARD	300 N COLUMBIA AVE		SEWARD	NE	68434	2299
470379039	02	YORK GEN HOSP INC	2222 LINCOLN AVE		YORK	NE	68467	1030
470379834	00	BEATRICE COMM HOSP & HEALTH CT	4800 HOSPITAL PKWY		BEATRICE	NE	68310	6906
470388012	00	BRODSTONE MEM-NUCKOLLS CO HOSP	520 E 10TH STREET	PO BOX 187	SUPERIOR	NE	68978	0187
470393176	01	ANTELOPE MEM HOSP	102 W 9TH ST	BOX 229	NELIGH	NE	68756	0229
470395787	00	HARLAN COUNTY HEALTH SYSTEM	717 NORTH BROWN		ALMA	NE	68920	2132
470395795	00	OGALLALA COMMUNITY HOSPITAL	2601 N SPRUCE ST		OGALLALA	NE	69153	2465
470399853	00	ALEGENT HLTH MEMORIAL HOSP-SCHUYLER	104 W 17TH ST		SCHUYLER	NE	68661	1304
470408242	00	SIDNEY REGIONAL MEDICAL CENTER	645 OSAGE ST		SIDNEY	NE	69162	1714
470421272	00	COMMUNITY MEDICAL CENTER INC	PO BOX 399	3307 BARADA ST	FALLS CITY	NE	68355	2470
470426285	00	BLAIR MEM COMM HOSP	810 N 22ND ST		BLAIR	NE	68008	1128
470426530	00	JENNIE M MELHAM MEM MED CTR	145 MEMORIAL DR	PO BOX 250	BROKEN BOW	NE	68822	0250
470443636	00	ST MARYS HOSP-NE CITY	1301 GRUNDMAN BLVD		NEBRASKA CIT	NE	68410	3319
470461859	01	AURORA MEM HOSP	1423 7TH ST		AURORA	NE	68818	1141
470463911	00	AVERA ST ANTHONYS HOSP-ONEILL	PO BOX 270	300 N 2ND ST	ONEILL	NE	68763	1514
470466032	00	WEBSTER CO COMM HOSP	6TH & FRANKLIN STS	PO BOX 465	RED CLOUD	NE	68970	0465
470468078	01	JEFFERSON COMMUNITY HEALTH CENTER	2200 H ST	BOX 277	FAIRBURY	NE	68352	1119
470471042	00	NEMAHA CO HOSP	2022 13TH ST		AUBURN	NE	68305	1799
470481628	00	PHELPS MEM HLTH CTR	1215 TIBBALS STREET		HOLDREGE	NE	68949	1255
470482234	00	CHADRON COMM HOSP & HLTH SERVICES	825 CENTENNIAL DR		CHADRON	NE	69337	9400
470485275	00	VALLEY COUNTY HOSPITAL	2707 L ST		ORD	NE	68862	1275
470486026	00	ST FRANCIS MEMORIAL HOSP-WEST POINT	430 N MONITOR ST		WEST POINT	NE	68788	1595
470487831	00	DUNDY CO HOSP	1313 N CHEYENNE ST	PO BOX 626	BENKELMAN	NE	69021	0626
470529089	00	FILLMORE COUNTY HOSPITAL	1900 F ST		GENEVA	NE	68361	2229
470532256	00	BROWN CO HOSP	945 E ZERO		AINSWORTH	NE	69210	1556
470532605	00	GOTHENBURG MEM HOSP	910 20TH ST		GOTHENBURG	NE	69138	0469
470533032	00	GORDON MEM HOSP-GORDON	300 E 8TH ST		GORDON	NE	69343	1123
470533373	00	COMMUNITY HOSPITAL-MCCOOK	1301 EAST H ST	PO BOX 1328	MCCOOK	NE	69001	3482
470533576	00	CALLAWAY DISTRICT HOSPITAL	211 EAST KIMBALL ST		CALLAWAY	NE	68825	2597
470537192	00	NIOBRARA VALLEY HOSP-LYNCH	BOX 118		LYNCH	NE	68746	0118
470538792	00	CHERRY CO HOSP	510 N GREEN ST	PO BOX 410	VALENTINE	NE	69201	1932
470544098	00	WEST HOLT MEM HOSP	406 WEST NEELY ST		ATKINSON	NE	68713	4801
470547317	00	MORRILL CO COMM HOSP	1313 S ST		BRIDGEPORT	NE	69336	2563
470551144	00	BUTLER CO HEALTH CARE CTR HOSP	372 S 9TH ST		DAVID CITY	NE	68632	2116
470557565	00	BOX BUTTE GEN HOSP	2101 BOX BUTTE AVE	PO BOX 810	ALLIANCE	NE	69301	0810
470566524	00	PROVIDENCE MED CTR-WAYNE	1200 PROVIDENCE RD		WAYNE	NE	68787	1212
470627838	10	THAYER CO MEM HOSP	120 PARK AVE		HEBRON	NE	68370	2019
470681056	00	HOWARD COUNTY MEDICAL CENTER	1113 SHERMAN ST	PO BOX 406	ST PAUL	NE	68873	0406
470711662	00	PENDER COMM HOSP	100 HOSPITAL DR	PO BOX 100	PENDER	NE	68047	5020
470761817	00	COMM MEM HOSP-SYRACUSE	1579 MIDLAND STREET	BOX N	SYRACUSE	NE	68446	0518

PROVIDER NUMBER		BUSINESS NAME	LINE 1 ADDRESS	LINE 2 ADDRESS	CITY NAME	POSTAL CODE	OFFICE ZIP CODE	
470765991	00	LITZENBERG MEM CO HOSP	1715 26TH ST		CENTRAL CITY	NE	68826	9501
470841285	00	CRETE AREA MEDICAL CENTER	2910 BETTEN DR		CRETE	NE	68333	3084
476000549	01	WARREN MEM HOSP	905 2ND ST		FRIEND	NE	68359	1133
476000611	00	BOONE CO HLTH CTR	723 W FAIRVIEW ST	PO BOX 151	ALBION	NE	68620	0151
476000710	00	ANNIE JEFFREY MEM CO HOSP	531 BEEBE ST	BOX 428	OSCEOLA	NE	68651	0428
476000803	01	CHASE CO COMM HOSP	600 W 12TH ST		IMPERIAL	NE	69033	3131
476000874	00	JOHNSON CO HOSP	202 HIGH ST		TECUMSEH	NE	68450	5990
476000999	00	ROCK CO HOSP	102 E SOUTH ST		BASSETT	NE	68714	5512
476006197	01	CITY OF GENOA DBA GENOA COMM HOSP	706 EWING AVE		GENOA	NE	68640	0310
476007155	00	KIMBALL CO HOSP	ATTN INS DEPT	505 S BURG	KIMBALL	NE	69145	1313
476007158	00	SAUNDERS MEDICAL CENTER	1760 COUNTY RD J		WAHOO	NE	68066	4152
476007436	00	FRANKLIN CO MEM HOSP	1406 Q ST	PO BOX 315	FRANKLIN	NE	68939	0315
476007486	00	COZAD COMMUNITY HOSPITAL	300 E 12TH ST	PO BOX 108	COZAD	NE	69130	1505
476014070	00	KEARNEY CO HLTH SVCS	727 E 1ST ST		MINDEN	NE	68959	1705
476014365	00	PERKINS CO COMM HOSP	900 LINCOLN AVE		GRANT	NE	69140	3095
476028103	00	CAMBRIDGE MEM HOSP	1305 HIGHWAY 6 & 34		CAMBRIDGE	NE	69022	0488
							*As of 8/11/2015	

Attachment 15 redacted

Attachment 14
Quality Performance Program Measures – Contract Year One

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for medical services provided to members within 15 days of the date of receipt. The date of receipt is the date the MCO receives the claim.	95% within 15 days	20%
Pharmacy Claims Processing Timeliness - 7 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims from pharmacy providers for covered services within seven days of receipt. The date of receipt is the date the MCO receives the claim.	95% within 7 days	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal.	95% within 30 days	10%
Grievance Resolution Timeliness: The MCO must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed 90 calendar days from the day the MCO receives the grievance.	95% within 60 days	10%
PDL Compliance: The MCO shall dispense medications in PDL categories compliant with Nebraska State PDL Preferred Status at least 92% of the time each quarter.	95%	10%

Attachment 13 redacted

Attachment 12
Historical Transplant Cost Distribution Data

SFY2010 - SFY2014 Transplant Cost Distribution (Includes all costs incurred 3 months pre-transplant and 6 months post-transplant)

Transplant Type	Count
Heart	19
Bone Marrow/Stem Cell	52
Lung	4
Intestine and/or multivisceral	31
Kidney	15
Pancreas+Kidney	3
Total	**124**

Cohort	Count
CHIP M&F	5
AABD 00-20 M&F	34
AABD 21+ M&F	66
Family Under 1 M&F	3
Family 01-05 M&F	9
Family 06-20 F	2
Family 21+ M&F	4
Foster Care M&F	1
Total	**124**

Heart	
Rank	Cost
1	$ 1,843,415
2	$ 1,664,386
3	$ 862,119
4	$ 725,747
5	$ 459,912
6	$ 439,098
7	$ 430,384
8	$ 359,632
9	$ 339,912
10	$ 316,740
11	$ 304,950
12	$ 236,275
13	$ 235,756
14	$ 229,710
15	$ 194,606
16	$ 177,521
17	$ 167,799
18	$ 158,563
19	$ 147,202

Bone Marrow/Stem Cell	
Rank	Cost
1	$ 877,332
2	$ 632,422
3	$ 531,069
4	$ 504,091
5	$ 488,557
6	$ 381,914
7	$ 377,934
8	$ 334,005
9	$ 312,461
10	$ 291,962
11	$ 285,385
12	$ 267,608
13	$ 249,152
14	$ 224,812
15	$ 212,188
16	$ 208,497
17	$ 206,085
18	$ 190,365
19	$ 184,959
20	$ 184,690
21	$ 184,470
22	$ 182,629
23	$ 179,030
24	$ 177,291
25	$ 176,417
26	$ 174,747
27	$ 168,474
28	$ 162,828
29	$ 158,860
30	$ 155,672
31	$ 154,041
32	$ 153,028
33	$ 151,876
34	$ 134,560
35	$ 131,454
36	$ 126,462
37	$ 117,818
38	$ 117,662
39	$ 112,237
40	$ 105,850
41	$ 104,860
42	$ 102,751
43	$ 101,320
44	$ 97,735
45	$ 94,492
46	$ 87,681
47	$ 87,322
48	$ 78,791
49	$ 76,945
50	$ 55,928
51	$ 47,986
52	$ 46,559

Lung	
Rank	Cost
1	$ 673,769
2	$ 495,988
3	$ 386,653
4	$ 246,727

Intestine and/or multivisceral	
Rank	Cost
1	$ 766,153
2	$ 448,698
3	$ 390,869
4	$ 354,430
5	$ 346,833
6	$ 335,171
7	$ 318,247
8	$ 251,180
9	$ 231,423
10	$ 218,689
11	$ 217,596
12	$ 200,021
13	$ 195,237
14	$ 186,868
15	$ 156,389
16	$ 154,246
17	$ 145,258
18	$ 143,301
19	$ 139,122
20	$ 138,977
21	$ 136,592
22	$ 133,467
23	$ 123,065
24	$ 111,424
25	$ 101,147
26	$ 97,571
27	$ 92,197
28	$ 91,864
29	$ 77,982
30	$ 66,342
31	$ 65,899

Kidney	
Rank	Cost
1	$ 292,755
2	$ 223,785
3	$ 160,179
4	$ 157,250
5	$ 141,681
6	$ 113,673
7	$ 111,164
8	$ 108,476
9	$ 105,916
10	$ 85,337
11	$ 83,407
12	$ 78,457
13	$ 77,969
14	$ 74,902
15	$ 61,217

Pancreas+Kidney	
Rank	Cost
1	$ 101,670
2	$ 87,625
3	$ 78,506

Attachment 11
Rates*

	Rating Region 1						Rating Region 2					
COA	**FY15 MMs**	**Medical PMPM**	**NML**	**Developed Rate**	**UNMC PMPM**	**Total Rate**	**FY15 MMs**	**Medical PMPM**	**NML**	**Developed Rate**	**UNMC PMPM**	**Total Rate**
AABD 00-20 M&F	35,303	$ 976.29	11.7%	$ 1,106.12	$ 16.28	$ 1,122.40	9,807	$ 1,123.17	11.7%	$ 1,272.16	$ 10.21	$ 1,282.37
AABD 21+ M&F	106,576	$ 1,406.62	11.8%	$ 1,595.12	$ 25.27	$ 1,620.39	27,407	$ 1,571.78	11.8%	$ 1,781.30	$ 8.23	$ 1,789.53
AABD 21+ M&F-WWC	1,109	$ 2,201.95	11.7%	$ 2,492.50	$ 108.11	$ 2,600.61	451	$ 2,532.75	11.6%	$ 2,866.19	$ 21.60	$ 2,887.79
CHIP M&F	317,346	$ 155.04	14.5%	$ 181.32	$ 4.64	$ 185.96	107,941	$ 153.32	14.5%	$ 179.26	$ 1.30	$ 180.56
Family Under 1 M&F	106,184	$ 460.76	10.7%	$ 516.26	$ 16.49	$ 532.75	32,855	$ 413.76	10.7%	$ 463.59	$ 3.97	$ 467.56
Family 01-05 M&F	332,138	$ 129.13	14.4%	$ 150.77	$ 5.44	$ 156.22	94,254	$ 137.24	14.3%	$ 160.21	$ 1.41	$ 161.62
Family 06-20 F	284,805	$ 149.92	14.6%	$ 175.51	$ 4.00	$ 179.51	82,972	$ 158.84	14.6%	$ 185.90	$ 1.18	$ 187.07
Family 06-20 M	272,407	$ 161.93	14.6%	$ 189.60	$ 3.52	$ 193.13	79,831	$ 164.67	14.6%	$ 192.82	$ 1.11	$ 193.93
Family 21+ M&F	224,680	$ 377.16	14.4%	$ 440.77	$ 10.89	$ 451.66	63,516	$ 461.18	14.4%	$ 538.94	$ 3.74	$ 542.68
Foster Care M&F	82,203	$ 452.29	11.3%	$ 509.67	$ 6.34	$ 516.01	22,223	$ 415.70	11.1%	$ 467.82	$ 3.24	$ 471.06
Katie Beckett 00-18 M&F	412	$ 12,654.24	2.9%	$ 13,031.59	$ 37.83	$ 13,069.41	412	$ 12,654.24	2.9%	$ 13,031.59	$ 37.83	$ 13,069.41
Maternity	6,649	$ 7,687.83	2.9%	$ 7,917.08	$ 332.23	$ 8,249.31	2,211	$ 7,504.02	2.9%	$ 7,727.79	$ 58.40	$ 7,786.19
LTSS (Institutional) - Dual	59,908	$ 230.31	11.8%	$ 261.00	$ -	$ 261.00	23,676	$ 195.31	11.7%	$ 221.28	$ -	$ 221.28
LTSS (Institutional) - Non-Dual	5,638	$ 2,876.09	11.7%	$ 3,256.61	$ -	$ 3,256.61	1,916	$ 1,974.47	11.7%	$ 2,235.72	$ -	$ 2,235.72
LTSS (Home and Community Based) - Dual	49,366	$ 271.09	11.8%	$ 307.35	$ 7.85	$ 315.20	22,675	$ 247.43	11.8%	$ 280.44	$ 1.69	$ 282.14
LTSS (Home and Community Based) - Non-Dual	28,342	$ 1,465.82	11.8%	$ 1,661.18	$ 15.60	$ 1,676.77	6,774	$ 1,340.45	11.7%	$ 1,518.85	$ 10.05	$ 1,528.90
Dual	193,309	$ 282.66	12.2%	$ 321.88	$ 7.08	$ 328.96	65,329	$ 239.11	12.1%	$ 271.97	$ 0.84	$ 272.81
Total (FY15 Mix)	**2,099,726**	**$ 348.84**	**12.1%**	**$ 396.86**	**$ 8.53**	**$ 405.39**	**642,039**	**$ 348.41**	**12.0%**	**$ 395.79**	**$ 2.40**	**$ 398.19**

*Rates will be updated with more recent data.

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Institutional)	DME/Supplies	59,908	$ 464,485	3,453	692	$ 134.50	$ 7.75
1	Dual	LTSS (Institutional)	Emergency Room	59,908	$ 518,769	2,376	476	$ 218.31	$ 8.66
1	Dual	LTSS (Institutional)	Emergency Transportation	59,908	$ 4,195	38	8	$ 109.70	$ 0.07
1	Dual	LTSS (Institutional)	EPSDT	59,908	$ -	-	-	$ -	$ -
1	Dual	LTSS (Institutional)	Family Planning	59,908	$ 89	5	1	$ 16.95	$ 0.00
1	Dual	LTSS (Institutional)	FQHC/RHC	59,908	$ 265,026	8,260	1,654	$ 32.09	$ 4.42
1	Dual	LTSS (Institutional)	Home Health	59,908	$ 378,175	96,936	19,417	$ 3.90	$ 6.31
1	Dual	LTSS (Institutional)	Hospice	59,908	$ 71,800	15,920	3,189	$ 4.51	$ 1.20
1	Dual	LTSS (Institutional)	Inpatient Hospital	59,908	$ 2,425,071	3,721	745	$ 651.73	$ 40.48
1	Dual	LTSS (Institutional)	Lab and Radiology	59,908	$ 19,280	3,766	754	$ 5.12	$ 0.32
1	Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	59,908	$ 11,415	111	22	$ 102.94	$ 0.19
1	Dual	LTSS (Institutional)	Other Care	59,908	$ 93,226	6,763	1,355	$ 13.78	$ 1.56
1	Dual	LTSS (Institutional)	Other Professional	59,908	$ 19,334	427	86	$ 45.27	$ 0.32
1	Dual	LTSS (Institutional)	Outpatient Hospital	59,908	$ 4,190,317	19,208	3,848	$ 218.15	$ 69.95
1	Dual	LTSS (Institutional)	PCP	59,908	$ 2,509,763	90,852	18,198	$ 27.62	$ 41.89
1	Dual	LTSS (Institutional)	Specialist	59,908	$ 7,613	200	40	$ 38.09	$ 0.13
1	Dual	LTSS (Institutional)	Vision	59,908	$ 246,515	1,569	314	$ 157.14	$ 4.11
1	Dual	LTSS (Institutional)	Rx	59,908	$ 473,227	173,610	34,775	$ 2.73	$ 7.90
1	Dual	LTSS (Institutional)	Behavioral Health - IP	59,908	$ 171,905	3,349	671	$ 51.33	$ 2.87
1	Dual	LTSS (Institutional)	Behavioral Health - OP	59,908	$ 437,876	8,370	1,677	$ 52.31	$ 7.31
1	Dual	LTSS (Institutional)	Behavioral Health - Other	59,908	$ 84,742	2,800	561	$ 30.27	$ 1.41
1	Dual	LTSS (Institutional)	Behavioral Health - Residential	59,908	$ 92,691	356	71	$ 260.71	$ 1.55
1	Non-Dual	LTSS (Institutional)	DME/Supplies	5,638	$ 214,491	677	1,441	$ 316.83	$ 38.04
1	Non-Dual	LTSS (Institutional)	Emergency Room	5,638	$ 264,461	370	787	$ 715.52	$ 46.91
1	Non-Dual	LTSS (Institutional)	Emergency Transportation	5,638	$ 63,905	212	450	$ 301.93	$ 11.33
1	Non-Dual	LTSS (Institutional)	EPSDT	5,638	$ 317	3	6	$ 104.60	$ 0.06
1	Non-Dual	LTSS (Institutional)	Family Planning	5,638	$ 159	6	12	$ 28.60	$ 0.03
1	Non-Dual	LTSS (Institutional)	FQHC/RHC	5,638	$ 85,028	678	1,443	$ 125.40	$ 15.08
1	Non-Dual	LTSS (Institutional)	Home Health	5,638	$ 24,769	10,274	21,868	$ 2.41	$ 4.39
1	Non-Dual	LTSS (Institutional)	Hospice	5,638	$ 604,511	135,740	288,911	$ 4.45	$ 107.22
1	Non-Dual	LTSS (Institutional)	Inpatient Hospital	5,638	$ 5,859,513	433	922	$ 13,528.44	$ 1,039.29
1	Non-Dual	LTSS (Institutional)	Lab and Radiology	5,638	$ 123,251	6,892	14,670	$ 17.88	$ 21.86
1	Non-Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	5,638	$ 87,737	353	752	$ 248.24	$ 15.56
1	Non-Dual	LTSS (Institutional)	Other Care	5,638	$ 720,833	3,374	7,182	$ 213.62	$ 127.85
1	Non-Dual	LTSS (Institutional)	Other Professional	5,638	$ 57,113	577	1,229	$ 98.91	$ 10.13
1	Non-Dual	LTSS (Institutional)	Outpatient Hospital	5,638	$ 1,288,623	4,642	9,880	$ 277.61	$ 228.56
1	Non-Dual	LTSS (Institutional)	PCP	5,638	$ 902,983	8,996	19,147	$ 100.38	$ 160.16
1	Non-Dual	LTSS (Institutional)	Specialist	5,638	$ 216,118	1,462	3,112	$ 147.79	$ 38.33
1	Non-Dual	LTSS (Institutional)	Vision	5,638	$ 37,128	457	972	$ 81.29	$ 6.59
1	Non-Dual	LTSS (Institutional)	Rx	5,638	$ 3,839,095	70,810	150,713	$ 54.22	$ 680.93
1	Non-Dual	LTSS (Institutional)	Behavioral Health - IP	5,638	$ 128,404	786	1,673	$ 163.34	$ 22.77
1	Non-Dual	LTSS (Institutional)	Behavioral Health - OP	5,638	$ 135,856	1,885	4,013	$ 72.06	$ 24.10
1	Non-Dual	LTSS (Institutional)	Behavioral Health - Other	5,638	$ 39,627	5,082	10,817	$ 7.80	$ 7.03
1	Non-Dual	LTSS (Institutional)	Behavioral Health - Residential	5,638	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Home and Community Based)	DME/Supplies	49,366	$ 1,976,640	20,886	5,077	$ 94.64	$ 40.04
1	Dual	LTSS (Home and Community Based)	Emergency Room	49,366	$ 392,201	2,652	645	$ 147.87	$ 7.94
1	Dual	LTSS (Home and Community Based)	Emergency Transportation	49,366	$ 2,150	20	5	$ 108.39	$ 0.04
1	Dual	LTSS (Home and Community Based)	EPSDT	49,366	$ 77	1	0	$ 73.94	$ 0.00
1	Dual	LTSS (Home and Community Based)	Family Planning	49,366	$ 8,364	228	55	$ 36.65	$ 0.17
1	Dual	LTSS (Home and Community Based)	FQHC/RHC	49,366	$ 120,604	3,594	874	$ 33.55	$ 2.44
1	Dual	LTSS (Home and Community Based)	Home Health	49,366	$ 1,904,454	650,132	158,035	$ 2.93	$ 38.58
1	Dual	LTSS (Home and Community Based)	Hospice	49,366	$ 6,110	666	162	$ 9.17	$ 0.12
1	Dual	LTSS (Home and Community Based)	Inpatient Hospital	49,366	$ 1,114,123	1,255	305	$ 887.81	$ 22.57
1	Dual	LTSS (Home and Community Based)	Lab and Radiology	49,366	$ 15,660	4,078	991	$ 3.84	$ 0.32
1	Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	49,366	$ 2,324	25	6	$ 92.76	$ 0.05
1	Dual	LTSS (Home and Community Based)	Other Care	49,366	$ 998,633	22,555	5,483	$ 44.28	$ 20.23
1	Dual	LTSS (Home and Community Based)	Other Professional	49,366	$ 56,818	882	214	$ 64.45	$ 1.15
1	Dual	LTSS (Home and Community Based)	Outpatient Hospital	49,366	$ 1,618,741	9,536	2,318	$ 169.75	$ 32.79
1	Dual	LTSS (Home and Community Based)	PCP	49,366	$ 2,442,662	82,042	19,943	$ 29.77	$ 49.48
1	Dual	LTSS (Home and Community Based)	Specialist	49,366	$ 5,035	214	52	$ 23.52	$ 0.10
1	Dual	LTSS (Home and Community Based)	Vision	49,366	$ 254,293	2,347	570	$ 108.37	$ 5.15
1	Dual	LTSS (Home and Community Based)	Rx	49,366	$ 370,632	104,629	25,433	$ 3.54	$ 7.51
1	Dual	LTSS (Home and Community Based)	Behavioral Health - IP	49,366	$ 72,744	374	91	$ 194.34	$ 1.47
1	Dual	LTSS (Home and Community Based)	Behavioral Health - OP	49,366	$ 836,032	16,982	4,128	$ 49.23	$ 16.94
1	Dual	LTSS (Home and Community Based)	Behavioral Health - Other	49,366	$ 101,432	8,653	2,103	$ 11.72	$ 2.05
1	Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	49,366	$ 15,999	51	12	$ 315.04	$ 0.32
1	Non-Dual	LTSS (Home and Community Based)	DME/Supplies	28,342	$ 5,356,758	24,693	10,455	$ 216.93	$ 189.00
1	Non-Dual	LTSS (Home and Community Based)	Emergency Room	28,342	$ 522,598	1,448	613	$ 360.99	$ 18.44
1	Non-Dual	LTSS (Home and Community Based)	Emergency Transportation	28,342	$ 67,649	243	103	$ 277.84	$ 2.39
1	Non-Dual	LTSS (Home and Community Based)	EPSDT	28,342	$ 8,248	81	34	$ 101.56	$ 0.29
1	Non-Dual	LTSS (Home and Community Based)	Family Planning	28,342	$ 20,577	292	123	$ 70.55	$ 0.73
1	Non-Dual	LTSS (Home and Community Based)	FQHC/RHC	28,342	$ 110,846	1,027	435	$ 107.96	$ 3.91
1	Non-Dual	LTSS (Home and Community Based)	Home Health	28,342	$ 2,780,799	399,977	169,350	$ 6.95	$ 98.12
1	Non-Dual	LTSS (Home and Community Based)	Hospice	28,342	$ 187,735	36,217	15,334	$ 5.18	$ 6.62
1	Non-Dual	LTSS (Home and Community Based)	Inpatient Hospital	28,342	$ 6,053,571	478	202	$ 12,668.78	$ 213.59
1	Non-Dual	LTSS (Home and Community Based)	Lab and Radiology	28,342	$ 222,352	12,306	5,210	$ 18.07	$ 7.85
1	Non-Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	28,342	$ 32,109	130	55	$ 247.13	$ 1.13
1	Non-Dual	LTSS (Home and Community Based)	Other Care	28,342	$ 1,389,632	23,343	9,883	$ 59.53	$ 49.03
1	Non-Dual	LTSS (Home and Community Based)	Other Professional	28,342	$ 187,103	1,705	722	$ 109.77	$ 6.60
1	Non-Dual	LTSS (Home and Community Based)	Outpatient Hospital	28,342	$ 2,481,349	7,311	3,095	$ 339.41	$ 87.55
1	Non-Dual	LTSS (Home and Community Based)	PCP	28,342	$ 1,574,524	19,378	8,205	$ 81.25	$ 55.55
1	Non-Dual	LTSS (Home and Community Based)	Specialist	28,342	$ 365,732	2,524	1,069	$ 144.88	$ 12.90
1	Non-Dual	LTSS (Home and Community Based)	Vision	28,342	$ 117,733	1,481	627	$ 79.50	$ 4.15
1	Non-Dual	LTSS (Home and Community Based)	Rx	28,342	$ 13,483,094	136,465	57,779	$ 98.80	$ 475.73
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - IP	28,342	$ 287,128	567	240	$ 506.19	$ 10.13
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - OP	28,342	$ 885,134	12,397	5,249	$ 71.40	$ 31.23
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Other	28,342	$ 159,851	16,651	7,050	$ 9.60	$ 5.64
1	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	28,342	$ 5,643	16	7	$ 349.62	$ 0.20

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
2	Dual	LTSS (Institutional)	DME/Supplies	23,676	$ 163,989	1,748	886	$ 93.80	$ 6.93
2	Dual	LTSS (Institutional)	Emergency Room	23,676	$ 294,245	963	488	$ 305.68	$ 12.43
2	Dual	LTSS (Institutional)	Emergency Transportation	23,676	$ 1,288	7	3	$ 195.62	$ 0.05
2	Dual	LTSS (Institutional)	EPSDT	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	Family Planning	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	FQHC/RHC	23,676	$ 133,708	4,586	2,324	$ 29.16	$ 5.65
2	Dual	LTSS (Institutional)	Home Health	23,676	$ 51,628	20,353	10,316	$ 2.54	$ 2.18
2	Dual	LTSS (Institutional)	Hospice	23,676	$ -	-	-	$ -	$ -
2	Dual	LTSS (Institutional)	Inpatient Hospital	23,676	$ 799,101	1,364	691	$ 585.87	$ 33.75
2	Dual	LTSS (Institutional)	Lab and Radiology	23,676	$ 2,849	620	314	$ 4.59	$ 0.12
2	Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	23,676	$ 7,832	41	21	$ 191.40	$ 0.33
2	Dual	LTSS (Institutional)	Other Care	23,676	$ 11,775	1,608	815	$ 7.32	$ 0.50
2	Dual	LTSS (Institutional)	Other Professional	23,676	$ 2,421	71	36	$ 34.22	$ 0.10
2	Dual	LTSS (Institutional)	Outpatient Hospital	23,676	$ 1,375,311	6,676	3,384	$ 206.00	$ 58.09
2	Dual	LTSS (Institutional)	PCP	23,676	$ 800,954	30,076	15,244	$ 26.63	$ 33.83
2	Dual	LTSS (Institutional)	Specialist	23,676	$ 3,104	61	31	$ 51.01	$ 0.13
2	Dual	LTSS (Institutional)	Vision	23,676	$ 97,754	475	241	$ 205.58	$ 4.13
2	Dual	LTSS (Institutional)	Rx	23,676	$ 187,389	67,291	34,106	$ 2.78	$ 7.91
2	Dual	LTSS (Institutional)	Behavioral Health - IP	23,676	$ 56,424	704	357	$ 80.11	$ 2.38
2	Dual	LTSS (Institutional)	Behavioral Health - OP	23,676	$ 135,154	2,645	1,341	$ 51.09	$ 5.71
2	Dual	LTSS (Institutional)	Behavioral Health - Other	23,676	$ 8,124	403	204	$ 20.15	$ 0.34
2	Dual	LTSS (Institutional)	Behavioral Health - Residential	23,676	$ 24,408	72	36	$ 340.56	$ 1.03
2	Non-Dual	LTSS (Institutional)	DME/Supplies	1,916	$ 33,788	281	1,763	$ 120.06	$ 17.63
2	Non-Dual	LTSS (Institutional)	Emergency Room	1,916	$ 70,520	86	541	$ 816.37	$ 36.81
2	Non-Dual	LTSS (Institutional)	Emergency Transportation	1,916	$ 17,936	35	219	$ 512.56	$ 9.36
2	Non-Dual	LTSS (Institutional)	EPSDT	1,916	$ 169	1	9	$ 114.78	$ 0.09
2	Non-Dual	LTSS (Institutional)	Family Planning	1,916	$ -	-	-	$ -	$ -
2	Non-Dual	LTSS (Institutional)	FQHC/RHC	1,916	$ 17,161	234	1,467	$ 73.25	$ 8.96
2	Non-Dual	LTSS (Institutional)	Home Health	1,916	$ 2,191	1,691	10,591	$ 1.30	$ 1.14
2	Non-Dual	LTSS (Institutional)	Hospice	1,916	$ 50,037	10,976	68,741	$ 4.56	$ 26.12
2	Non-Dual	LTSS (Institutional)	Inpatient Hospital	1,916	$ 1,083,015	99	622	$ 10,911.34	$ 565.25
2	Non-Dual	LTSS (Institutional)	Lab and Radiology	1,916	$ 25,832	1,180	7,393	$ 21.88	$ 13.48
2	Non-Dual	LTSS (Institutional)	Non-Emergency Transportation - Ambulance	1,916	$ 20,846	52	327	$ 399.01	$ 10.88
2	Non-Dual	LTSS (Institutional)	Other Care	1,916	$ 62,036	531	3,325	$ 116.87	$ 32.38
2	Non-Dual	LTSS (Institutional)	Other Professional	1,916	$ 16,475	181	1,131	$ 91.21	$ 8.60
2	Non-Dual	LTSS (Institutional)	Outpatient Hospital	1,916	$ 385,939	1,423	8,910	$ 271.29	$ 201.43
2	Non-Dual	LTSS (Institutional)	PCP	1,916	$ 216,653	2,146	13,440	$ 100.96	$ 113.08
2	Non-Dual	LTSS (Institutional)	Specialist	1,916	$ 33,863	234	1,467	$ 144.54	$ 17.67
2	Non-Dual	LTSS (Institutional)	Vision	1,916	$ 9,584	80	500	$ 120.04	$ 5.00
2	Non-Dual	LTSS (Institutional)	Rx	1,916	$ 1,237,537	21,383	133,924	$ 57.87	$ 645.90
2	Non-Dual	LTSS (Institutional)	Behavioral Health - IP	1,916	$ 19,573	103	647	$ 189.49	$ 10.22
2	Non-Dual	LTSS (Institutional)	Behavioral Health - OP	1,916	$ 33,226	707	4,430	$ 46.98	$ 17.34
2	Non-Dual	LTSS (Institutional)	Behavioral Health - Other	1,916	$ 604	17	105	$ 35.93	$ 0.32
2	Non-Dual	LTSS (Institutional)	Behavioral Health - Residential	1,916	$ 4,517	28	173	$ 163.30	$ 2.36

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-D
Long-Term Services and Supports Databook

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
2	Dual	LTSS (Home and Community Based)	DME/Supplies	22,675	$ 647,375	9,275	4,909	$ 69.80	$ 28.55
2	Dual	LTSS (Home and Community Based)	Emergency Room	22,675	$ 290,713	1,202	636	$ 241.88	$ 12.82
2	Dual	LTSS (Home and Community Based)	Emergency Transportation	22,675	$ 251	6	3	$ 43.68	$ 0.01
2	Dual	LTSS (Home and Community Based)	EPSDT	22,675	$ -	-	-	$ -	$ -
2	Dual	LTSS (Home and Community Based)	Family Planning	22,675	$ 3,189	99	52	$ 32.24	$ 0.14
2	Dual	LTSS (Home and Community Based)	FQHC/RHC	22,675	$ 89,258	2,756	1,458	$ 32.39	$ 3.94
2	Dual	LTSS (Home and Community Based)	Home Health	22,675	$ 234,491	76,484	40,477	$ 3.07	$ 10.34
2	Dual	LTSS (Home and Community Based)	Hospice	22,675	$ -	-	33	$ -	$ -
2	Dual	LTSS (Home and Community Based)	Inpatient Hospital	22,675	$ 557,247	629	333	$ 885.24	$ 24.58
2	Dual	LTSS (Home and Community Based)	Lab and Radiology	22,675	$ 2,917	1,254	664	$ 2.33	$ 0.13
2	Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	22,675	$ 3,147	19	10	$ 167.45	$ 0.14
2	Dual	LTSS (Home and Community Based)	Other Care	22,675	$ 141,504	3,953	2,092	$ 35.80	$ 6.24
2	Dual	LTSS (Home and Community Based)	Other Professional	22,675	$ 5,041	106	56	$ 47.45	$ 0.22
2	Dual	LTSS (Home and Community Based)	Outpatient Hospital	22,675	$ 1,272,089	6,449	3,413	$ 197.26	$ 56.10
2	Dual	LTSS (Home and Community Based)	PCP	22,675	$ 1,219,729	44,268	23,427	$ 27.55	$ 53.79
2	Dual	LTSS (Home and Community Based)	Specialist	22,675	$ 2,701	67	35	$ 40.31	$ 0.12
2	Dual	LTSS (Home and Community Based)	Vision	22,675	$ 128,230	1,026	543	$ 125.01	$ 5.66
2	Dual	LTSS (Home and Community Based)	Rx	22,675	$ 152,107	48,305	25,564	$ 3.15	$ 6.71
2	Dual	LTSS (Home and Community Based)	Behavioral Health - IP	22,675	$ 26,113	149	79	$ 174.74	$ 1.15
2	Dual	LTSS (Home and Community Based)	Behavioral Health - OP	22,675	$ 284,349	4,746	2,512	$ 59.91	$ 12.54
2	Dual	LTSS (Home and Community Based)	Behavioral Health - Other	22,675	$ 50,912	2,173	1,150	$ 23.43	$ 2.25
2	Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	22,675	$ 4,134	12	6	$ 347.50	$ 0.18
2	Non-Dual	LTSS (Home and Community Based)	DME/Supplies	6,774	$ 1,447,140	6,257	11,084	$ 231.29	$ 213.63
2	Non-Dual	LTSS (Home and Community Based)	Emergency Room	6,774	$ 194,621	315	558	$ 617.69	$ 28.73
2	Non-Dual	LTSS (Home and Community Based)	Emergency Transportation	6,774	$ 15,701	59	105	$ 265.21	$ 2.32
2	Non-Dual	LTSS (Home and Community Based)	EPSDT	6,774	$ 1,035	14	26	$ 71.86	$ 0.15
2	Non-Dual	LTSS (Home and Community Based)	Family Planning	6,774	$ 6,570	91	161	$ 72.27	$ 0.97
2	Non-Dual	LTSS (Home and Community Based)	FQHC/RHC	6,774	$ 54,774	534	946	$ 102.57	$ 8.09
2	Non-Dual	LTSS (Home and Community Based)	Home Health	6,774	$ 155,110	38,927	68,958	$ 3.98	$ 22.90
2	Non-Dual	LTSS (Home and Community Based)	Hospice	6,774	$ 8,149	1,768	3,132	$ 4.61	$ 1.20
2	Non-Dual	LTSS (Home and Community Based)	Inpatient Hospital	6,774	$ 1,287,510	119	211	$ 10,816.48	$ 190.07
2	Non-Dual	LTSS (Home and Community Based)	Lab and Radiology	6,774	$ 54,398	2,718	4,815	$ 20.01	$ 8.03
2	Non-Dual	LTSS (Home and Community Based)	Non-Emergency Transportation - Ambulance	6,774	$ 17,067	28	50	$ 601.89	$ 2.52
2	Non-Dual	LTSS (Home and Community Based)	Other Care	6,774	$ 329,671	5,859	10,379	$ 56.27	$ 48.67
2	Non-Dual	LTSS (Home and Community Based)	Other Professional	6,774	$ 34,424	399	707	$ 86.29	$ 5.08
2	Non-Dual	LTSS (Home and Community Based)	Outpatient Hospital	6,774	$ 984,451	2,317	4,104	$ 424.94	$ 145.33
2	Non-Dual	LTSS (Home and Community Based)	PCP	6,774	$ 420,637	5,060	8,963	$ 83.13	$ 62.10
2	Non-Dual	LTSS (Home and Community Based)	Specialist	6,774	$ 70,729	677	1,199	$ 104.53	$ 10.44
2	Non-Dual	LTSS (Home and Community Based)	Vision	6,774	$ 35,880	381	675	$ 94.16	$ 5.30
2	Non-Dual	LTSS (Home and Community Based)	Rx	6,774	$ 2,559,655	39,072	69,215	$ 65.51	$ 377.86
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - IP	6,774	$ 56,533	138	244	$ 411.15	$ 8.35
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - OP	6,774	$ 191,494	2,525	4,474	$ 75.83	$ 28.27
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Other	6,774	$ 25,252	2,706	4,794	$ 9.33	$ 3.73
2	Non-Dual	LTSS (Home and Community Based)	Behavioral Health - Residential	6,774	$ 880	3	4	$ 347.50	$ 0.13

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

				Base Data*					
Rating Region	Dual Status	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	LTSS (Institutional)	ALL	59,908	$ 12,485,515	442,091	88,554	$ 28.24	$ 208.41
1	Non-Dual	LTSS (Institutional)	ALL	5,638	$ 14,693,920	253,710	540,001	$ 57.92	$ 2,606.23
1	Dual	LTSS (Home and Community Based)	ALL	49,366	$ 12,315,729	931,801	226,504	$ 13.22	$ 249.48
1	Non-Dual	LTSS (Home and Community Based)	ALL	28,342	$ 36,300,166	698,729	295,842	$ 51.95	$ 1,280.79
2	Dual	LTSS (Institutional)	ALL	23,676	$ 4,157,457	139,764	70,838	$ 29.75	$ 175.60
2	Non-Dual	LTSS (Institutional)	ALL	1,916	$ 3,341,502	41,469	259,724	$ 80.58	$ 1,744.00
2	Dual	LTSS (Home and Community Based)	ALL	22,675	$ 5,115,497	202,979	107,420	$ 25.20	$ 225.60
2	Non-Dual	LTSS (Home and Community Based)	ALL	6,774	$ 7,951,683	109,966	194,803	$ 72.31	$ 1,173.85
Total				**198,295**	**$ 96,361,468**	**2,820,510**	**170,686**	**$ 34.16**	**$ 485.95**

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-C
Dual Databook

			Base Data*					
Rating Region	Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	DME/Supplies	193,309	$ 1,790,811	20,167	1,252	$ 88.80	$ 9.26
1	Dual	Emergency Room	193,309	$ 2,425,161	18,330	1,138	$ 132.31	$ 12.55
1	Dual	Emergency Transportation	193,309	$ 18,116	128	8	$ 141.64	$ 0.09
1	Dual	EPSDT	193,309	$ -	-	0	$ -	$ -
1	Dual	Family Planning	193,309	$ 31,904	298	19	$ 106.93	$ 0.17
1	Dual	FQHC/RHC	193,309	$ 643,229	18,512	1,149	$ 34.75	$ 3.33
1	Dual	Home Health	193,309	$ 4,782,498	1,835,032	113,913	$ 2.61	$ 24.74
1	Dual	Hospice	193,309	$ 11,380	2,226	138	$ 5.11	$ 0.06
1	Dual	Inpatient Hospital	193,309	$ 5,259,466	5,929	368	$ 887.06	$ 27.21
1	Dual	Lab and Radiology	193,309	$ 103,643	19,743	1,226	$ 5.25	$ 0.54
1	Dual	Non-Emergency Transportation - Ambulance	193,309	$ 9,871	78	5	$ 126.96	$ 0.05
1	Dual	Other Care	193,309	$ 228,959	23,022	1,429	$ 9.95	$ 1.18
1	Dual	Other Professional	193,309	$ 104,470	1,813	113	$ 57.61	$ 0.54
1	Dual	Outpatient Hospital	193,309	$ 9,360,528	48,478	3,009	$ 193.09	$ 48.42
1	Dual	PCP	193,309	$ 11,470,508	357,053	22,165	$ 32.13	$ 59.34
1	Dual	Specialist	193,309	$ 49,825	988	61	$ 50.42	$ 0.26
1	Dual	Vision	193,309	$ 744,234	6,651	413	$ 111.89	$ 3.85
1	Dual	Rx	193,309	$ 278,206	58,789	3,649	$ 4.73	$ 1.44
1	Dual	Behavioral Health - IP	193,309	$ 1,659,599	5,752	357	$ 288.53	$ 8.59
1	Dual	Behavioral Health - OP	193,309	$ 2,764,553	54,115	3,359	$ 51.09	$ 14.30
1	Dual	Behavioral Health - Other	193,309	$ 6,083,035	312,681	19,410	$ 19.45	$ 31.47
1	Dual	Behavioral Health - Residential	193,309	$ 4,742,089	30,133	1,871	$ 157.37	$ 24.53
2	Dual	DME/Supplies	65,329	$ 480,087	6,028	1,107	$ 79.64	$ 7.35
2	Dual	Emergency Room	65,329	$ 979,309	4,800	882	$ 204.01	$ 14.99
2	Dual	Emergency Transportation	65,329	$ 1,944	22	4	$ 88.20	$ 0.03
2	Dual	EPSDT	65,329	$ -	-	-	$ -	$ -
2	Dual	Family Planning	65,329	$ 12,502	108	20	$ 115.74	$ 0.19
2	Dual	FQHC/RHC	65,329	$ 289,968	8,780	1,613	$ 33.03	$ 4.44
2	Dual	Home Health	65,329	$ 192,297	65,531	12,037	$ 2.93	$ 2.94
2	Dual	Hospice	65,329	$ 8,003	1,382	254	$ 5.79	$ 0.12
2	Dual	Inpatient Hospital	65,329	$ 1,534,949	1,681	309	$ 913.24	$ 23.50
2	Dual	Lab and Radiology	65,329	$ 20,227	4,089	751	$ 4.95	$ 0.31
2	Dual	Non-Emergency Transportation - Ambulance	65,329	$ 10,012	54	10	$ 186.83	$ 0.15
2	Dual	Other Care	65,329	$ 36,743	4,649	854	$ 7.90	$ 0.56
2	Dual	Other Professional	65,329	$ 10,057	216	40	$ 46.66	$ 0.15
2	Dual	Outpatient Hospital	65,329	$ 4,116,370	18,616	3,420	$ 221.12	$ 63.01
2	Dual	PCP	65,329	$ 3,625,552	128,701	23,641	$ 28.17	$ 55.50
2	Dual	Specialist	65,329	$ 12,670	265	49	$ 47.85	$ 0.19
2	Dual	Vision	65,329	$ 296,669	2,344	431	$ 126.54	$ 4.54
2	Dual	Rx	65,329	$ 97,049	19,153	3,518	$ 5.07	$ 1.49
2	Dual	Behavioral Health - IP	65,329	$ 276,518	1,447	266	$ 191.11	$ 4.23
2	Dual	Behavioral Health - OP	65,329	$ 1,088,004	19,817	3,640	$ 54.90	$ 16.65
2	Dual	Behavioral Health - Other	65,329	$ 1,871,991	98,575	18,107	$ 18.99	$ 28.65
2	Dual	Behavioral Health - Residential	65,329	$ 294,729	1,591	292	$ 185.28	$ 4.51

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-C
Dual Databook

		Base Data*					
Rating Region	Population	MMs	Dollars	Units	Util/K	UC	PMPM
1	Dual	193,309	$ 52,562,084	2,819,919	175,051	$ 18.64	$ 271.91
2	Dual	65,329	$ 15,255,650	387,847	71,242	$ 39.33	$ 233.52
Total		**258,638**	**$ 67,817,734**	**3,207,767**	**148,830**	**$ 21.14**	**$ 262.21**

		Base Data*					
Population	COS	MMs	Dollars	Units	Util/K	UC	PMPM
Dual	DME/Supplies	258,638	$ 2,270,898	26,195	1,215	$ 86.69	$ 8.78
Dual	Emergency Room	258,638	$ 3,404,470	23,130	1,073	$ 147.19	$ 13.16
Dual	Emergency Transportation	258,638	$ 20,060	150	7	$ 133.78	$ 0.08
Dual	EPSDT	258,638	$ -	-	-	$ -	$ -
Dual	Family Planning	258,638	$ 44,406	406	19	$ 109.27	$ 0.17
Dual	FQHC/RHC	258,638	$ 933,197	27,292	1,266	$ 34.19	$ 3.61
Dual	Home Health	258,638	$ 4,974,795	1,900,563	88,180	$ 2.62	$ 19.23
Dual	Hospice	258,638	$ 19,383	3,608	167	$ 5.37	$ 0.07
Dual	Inpatient Hospital	258,638	$ 6,794,414	7,610	353	$ 892.84	$ 26.27
Dual	Lab and Radiology	258,638	$ 123,870	23,832	1,106	$ 5.20	$ 0.48
Dual	Non-Emergency Transportation - Ambulance	258,638	$ 19,883	131	6	$ 151.39	$ 0.08
Dual	Other Care	258,638	$ 265,701	27,670	1,284	$ 9.60	$ 1.03
Dual	Other Professional	258,638	$ 114,528	2,029	94	$ 56.45	$ 0.44
Dual	Outpatient Hospital	258,638	$ 13,476,898	67,095	3,113	$ 200.86	$ 52.11
Dual	PCP	258,638	$ 15,096,060	485,754	22,537	$ 31.08	$ 58.37
Dual	Specialist	258,638	$ 62,495	1,253	58	$ 49.88	$ 0.24
Dual	Vision	258,638	$ 1,040,902	8,996	417	$ 115.71	$ 4.02
Dual	Rx	258,638	$ 375,255	77,942	3,616	$ 4.81	$ 1.45
Dual	Behavioral Health - IP	258,638	$ 1,936,117	7,199	334	$ 268.95	$ 7.49
Dual	Behavioral Health - OP	258,638	$ 3,852,558	73,933	3,430	$ 52.11	$ 14.90
Dual	Behavioral Health - Other	258,638	$ 7,955,026	411,256	19,081	$ 19.34	$ 30.76
Dual	Behavioral Health - Residential	258,638	$ 5,036,817	31,724	1,472	$ 158.77	$ 19.47
Total		**258,638**	**$ 67,817,734**	**3,207,767**	**148,830**	**$ 21.14**	**$ 262.21**

*Base Data represents FY14 and FY15 for Physical Health and Behavioral Health services

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 00-20 M&F	DME/Supplies	9,807	$ 804,393	2,205	2,697	$ 364.89	$ 82.02
2	AABD 00-20 M&F	Emergency Room	9,807	$ 231,828	579	708	$ 400.56	$ 23.64
2	AABD 00-20 M&F	Emergency Transportation	9,807	$ 58,575	50	61	$ 1,167.31	$ 5.97
2	AABD 00-20 M&F	EPSDT	9,807	$ 21,537	185	226	$ 116.55	$ 2.20
2	AABD 00-20 M&F	Family Planning	9,807	$ 2,067	31	37	$ 67.55	$ 0.21
2	AABD 00-20 M&F	FQHC/RHC	9,807	$ 52,285	469	574	$ 111.42	$ 5.33
2	AABD 00-20 M&F	Home Health	9,807	$ 403,926	2,632	3,220	$ 153.48	$ 41.19
2	AABD 00-20 M&F	Hospice	9,807	$ 2,189	15	18	$ 150.10	$ 0.22
2	AABD 00-20 M&F	Inpatient Hospital	9,807	$ 1,754,990	84	103	$ 20,793.42	$ 178.95
2	AABD 00-20 M&F	Lab and Radiology	9,807	$ 40,858	963	1,179	$ 42.41	$ 4.17
2	AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	9,807	$ 3,198	5	6	$ 647.23	$ 0.33
2	AABD 00-20 M&F	Other Care	9,807	$ 407,598	3,811	4,664	$ 106.94	$ 41.56
2	AABD 00-20 M&F	Other Professional	9,807	$ 120,386	1,449	1,772	$ 83.11	$ 12.28
2	AABD 00-20 M&F	Outpatient Hospital	9,807	$ 1,492,441	1,833	2,243	$ 814.08	$ 152.18
2	AABD 00-20 M&F	PCP	9,807	$ 669,621	9,748	11,928	$ 68.69	$ 68.28
2	AABD 00-20 M&F	Specialist	9,807	$ 260,878	1,695	2,074	$ 153.90	$ 26.60
2	AABD 00-20 M&F	Vision	9,807	$ 48,105	297	363	$ 162.01	$ 4.91
2	AABD 00-20 M&F	Rx	9,807	$ 3,045,990	19,911	24,363	$ 152.98	$ 310.59
2	AABD 00-20 M&F	Behavioral Health - IP	9,807	$ 82,513	164	201	$ 502.89	$ 8.41
2	AABD 00-20 M&F	Behavioral Health - OP	9,807	$ 347,359	4,721	5,776	$ 73.58	$ 35.42
2	AABD 00-20 M&F	Behavioral Health - Residential	9,807	$ -	-	-	$ -	$ -
2	AABD 00-20 M&F	Behavioral Health - Other	9,807	$ 7,287	522	638	$ 13.97	$ 0.74

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 21+ M&F	DME/Supplies	27,407	$ 1,418,362	7,437	3,256	$ 190.71	$ 51.75
2	AABD 21+ M&F	Emergency Room	27,407	$ 2,065,790	2,844	1,245	$ 726.34	$ 75.37
2	AABD 21+ M&F	Emergency Transportation	27,407	$ 251,350	571	250	$ 440.18	$ 9.17
2	AABD 21+ M&F	EPSDT	27,407	$ -	-	-	$ -	$ -
2	AABD 21+ M&F	Family Planning	27,407	$ 11,665	100	44	$ 116.56	$ 0.43
2	AABD 21+ M&F	FQHC/RHC	27,407	$ 352,795	2,793	1,223	$ 126.29	$ 12.87
2	AABD 21+ M&F	Home Health	27,407	$ 195,640	5,885	2,577	$ 33.25	$ 7.14
2	AABD 21+ M&F	Hospice	27,407	$ 169,370	1,157	507	$ 146.37	$ 6.18
2	AABD 21+ M&F	Inpatient Hospital	27,407	$ 7,565,210	740	324	$ 10,225.35	$ 276.03
2	AABD 21+ M&F	Lab and Radiology	27,407	$ 311,123	14,156	6,198	$ 21.98	$ 11.35
2	AABD 21+ M&F	Non-Emergency Transportation - Ambulance	27,407	$ 17,567	31	14	$ 563.35	$ 0.64
2	AABD 21+ M&F	Other Care	27,407	$ 244,635	2,239	981	$ 109.24	$ 8.93
2	AABD 21+ M&F	Other Professional	27,407	$ 555,609	6,848	2,998	$ 81.13	$ 20.27
2	AABD 21+ M&F	Outpatient Hospital	27,407	$ 5,631,738	10,337	4,526	$ 544.81	$ 205.49
2	AABD 21+ M&F	PCP	27,407	$ 2,120,863	19,007	8,322	$ 111.58	$ 77.38
2	AABD 21+ M&F	Specialist	27,407	$ 1,439,431	10,975	4,805	$ 131.16	$ 52.52
2	AABD 21+ M&F	Vision	27,407	$ 181,328	933	408	$ 194.39	$ 6.62
2	AABD 21+ M&F	Rx	27,407	$ 12,734,264	125,641	55,011	$ 101.35	$ 464.64
2	AABD 21+ M&F	Behavioral Health - IP	27,407	$ 628,935	1,371	600	$ 458.75	$ 22.95
2	AABD 21+ M&F	Behavioral Health - OP	27,407	$ 864,757	12,841	5,622	$ 67.34	$ 31.55
2	AABD 21+ M&F	Behavioral Health - Residential	27,407	$ 200,651	1,251	548	$ 160.35	$ 7.32
2	AABD 21+ M&F	Behavioral Health - Other	27,407	$ 1,141,840	74,623	32,673	$ 15.30	$ 41.66

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and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 21+ M&F-WWC	DME/Supplies	451	$ 20,587	63	1,681	$ 325.93	$ 45.65
2	AABD 21+ M&F-WWC	Emergency Room	451	$ 21,489	27	711	$ 803.65	$ 47.65
2	AABD 21+ M&F-WWC	Emergency Transportation	451	$ 1,012	2	59	$ 457.08	$ 2.25
2	AABD 21+ M&F-WWC	EPSDT	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Family Planning	451	$ 28	1	24	$ 31.36	$ 0.06
2	AABD 21+ M&F-WWC	FQHC/RHC	451	$ 7,103	56	1,491	$ 126.78	$ 15.75
2	AABD 21+ M&F-WWC	Home Health	451	$ 1,411	41	1,087	$ 34.56	$ 3.13
2	AABD 21+ M&F-WWC	Hospice	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Inpatient Hospital	451	$ 142,561	18	467	$ 8,129.84	$ 316.10
2	AABD 21+ M&F-WWC	Lab and Radiology	451	$ 30,821	825	21,961	$ 37.34	$ 68.34
2	AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	451	$ 310	1	13	$ 618.66	$ 0.69
2	AABD 21+ M&F-WWC	Other Care	451	$ 13,116	127	3,388	$ 103.01	$ 29.08
2	AABD 21+ M&F-WWC	Other Professional	451	$ 5,654	38	1,001	$ 150.31	$ 12.54
2	AABD 21+ M&F-WWC	Outpatient Hospital	451	$ 546,460	489	13,006	$ 1,117.95	$ 1,211.66
2	AABD 21+ M&F-WWC	PCP	451	$ 148,233	658	17,508	$ 225.28	$ 328.68
2	AABD 21+ M&F-WWC	Specialist	451	$ 43,129	140	3,731	$ 307.58	$ 95.63
2	AABD 21+ M&F-WWC	Vision	451	$ 2,252	22	582	$ 102.89	$ 4.99
2	AABD 21+ M&F-WWC	Rx	451	$ 78,566	1,993	53,031	$ 39.42	$ 174.20
2	AABD 21+ M&F-WWC	Behavioral Health - IP	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Behavioral Health - OP	451	$ 666	9	252	$ 70.28	$ 1.48
2	AABD 21+ M&F-WWC	Behavioral Health - Residential	451	$ -	-	-	$ -	$ -
2	AABD 21+ M&F-WWC	Behavioral Health - Other	451	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	CHIP M&F	DME/Supplies	107,941	$ 202,464	1,115	124	$ 181.64	$ 1.88
2	CHIP M&F	Emergency Room	107,941	$ 1,113,100	2,782	309	$ 400.07	$ 10.31
2	CHIP M&F	Emergency Transportation	107,941	$ 37,313	67	7	$ 559.86	$ 0.35
2	CHIP M&F	EPSDT	107,941	$ 342,284	2,748	305	$ 124.57	$ 3.17
2	CHIP M&F	Family Planning	107,941	$ 21,253	163	18	$ 130.35	$ 0.20
2	CHIP M&F	FQHC/RHC	107,941	$ 458,337	4,079	453	$ 112.36	$ 4.25
2	CHIP M&F	Home Health	107,941	$ 6,331	98	11	$ 64.71	$ 0.06
2	CHIP M&F	Hospice	107,941	$ -	-	-	$ -	$ -
2	CHIP M&F	Inpatient Hospital	107,941	$ 968,202	137	15	$ 7,092.71	$ 8.97
2	CHIP M&F	Lab and Radiology	107,941	$ 113,234	4,613	513	$ 24.55	$ 1.05
2	CHIP M&F	Non-Emergency Transportation - Ambulance	107,941	$ 4,050	5	1	$ 754.23	$ 0.04
2	CHIP M&F	Other Care	107,941	$ 202,145	2,380	265	$ 84.93	$ 1.87
2	CHIP M&F	Other Professional	107,941	$ 624,978	10,351	1,151	$ 60.38	$ 5.79
2	CHIP M&F	Outpatient Hospital	107,941	$ 2,384,896	5,713	635	$ 417.43	$ 22.09
2	CHIP M&F	PCP	107,941	$ 2,081,934	26,435	2,939	$ 78.76	$ 19.29
2	CHIP M&F	Specialist	107,941	$ 541,009	5,466	608	$ 98.97	$ 5.01
2	CHIP M&F	Vision	107,941	$ 319,056	2,100	233	$ 151.94	$ 2.96
2	CHIP M&F	Rx	107,941	$ 3,806,639	53,881	5,990	$ 70.65	$ 35.27
2	CHIP M&F	Behavioral Health - IP	107,941	$ 185,228	356	40	$ 520.15	$ 1.72
2	CHIP M&F	Behavioral Health - OP	107,941	$ 1,191,195	16,371	1,820	$ 72.76	$ 11.04
2	CHIP M&F	Behavioral Health - Residential	107,941	$ 45,352	178	20	$ 255.17	$ 0.42
2	CHIP M&F	Behavioral Health - Other	107,941	$ 158	6	1	$ 24.60	$ 0.00

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family Under 1 M&F	DME/Supplies	32,855	$ 143,784	1,397	510	$ 102.89	$ 4.38
2	Family Under 1 M&F	Emergency Room	32,855	$ 636,570	3,446	1,259	$ 184.71	$ 19.38
2	Family Under 1 M&F	Emergency Transportation	32,855	$ 124,216	94	34	$ 1,318.64	$ 3.78
2	Family Under 1 M&F	EPSDT	32,855	$ 947,352	10,074	3,680	$ 94.04	$ 28.83
2	Family Under 1 M&F	Family Planning	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	FQHC/RHC	32,855	$ 185,510	1,992	728	$ 93.12	$ 5.65
2	Family Under 1 M&F	Home Health	32,855	$ 24,687	1,528	558	$ 16.16	$ 0.75
2	Family Under 1 M&F	Hospice	32,855	$ 1,177	8	3	$ 155.29	$ 0.04
2	Family Under 1 M&F	Inpatient Hospital	32,855	$ 5,003,818	1,666	609	$ 3,002.71	$ 152.30
2	Family Under 1 M&F	Lab and Radiology	32,855	$ 39,772	2,578	942	$ 15.42	$ 1.21
2	Family Under 1 M&F	Non-Emergency Transportation - Ambulance	32,855	$ 6,222	8	3	$ 828.47	$ 0.19
2	Family Under 1 M&F	Other Care	32,855	$ 267,095	1,194	436	$ 223.74	$ 8.13
2	Family Under 1 M&F	Other Professional	32,855	$ 295,074	4,635	1,693	$ 63.66	$ 8.98
2	Family Under 1 M&F	Outpatient Hospital	32,855	$ 1,009,604	3,096	1,131	$ 326.15	$ 30.73
2	Family Under 1 M&F	PCP	32,855	$ 2,310,648	29,669	10,836	$ 77.88	$ 70.33
2	Family Under 1 M&F	Specialist	32,855	$ 491,443	4,027	1,471	$ 122.04	$ 14.96
2	Family Under 1 M&F	Vision	32,855	$ 60,420	129	47	$ 466.94	$ 1.84
2	Family Under 1 M&F	Rx	32,855	$ 413,485	17,854	6,521	$ 23.16	$ 12.59
2	Family Under 1 M&F	Behavioral Health - IP	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	Behavioral Health - OP	32,855	$ 698	8	3	$ 87.59	$ 0.02
2	Family Under 1 M&F	Behavioral Health - Residential	32,855	$ -	-	-	$ -	$ -
2	Family Under 1 M&F	Behavioral Health - Other	32,855	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 01-05 M&F	DME/Supplies	94,254	$ 142,938	980	125	$ 145.82	$ 1.52
2	Family 01-05 M&F	Emergency Room	94,254	$ 1,242,306	4,714	600	$ 263.54	$ 13.18
2	Family 01-05 M&F	Emergency Transportation	94,254	$ 89,605	81	10	$ 1,110.67	$ 0.95
2	Family 01-05 M&F	EPSDT	94,254	$ 541,280	4,429	564	$ 122.20	$ 5.74
2	Family 01-05 M&F	Family Planning	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	FQHC/RHC	94,254	$ 355,637	3,230	411	$ 110.12	$ 3.77
2	Family 01-05 M&F	Home Health	94,254	$ 26,211	415	53	$ 63.17	$ 0.28
2	Family 01-05 M&F	Hospice	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Inpatient Hospital	94,254	$ 1,099,602	165	21	$ 6,660.44	$ 11.67
2	Family 01-05 M&F	Lab and Radiology	94,254	$ 60,401	3,069	391	$ 19.68	$ 0.64
2	Family 01-05 M&F	Non-Emergency Transportation - Ambulance	94,254	$ 3,102	5	1	$ 685.37	$ 0.03
2	Family 01-05 M&F	Other Care	94,254	$ 197,034	2,525	321	$ 78.04	$ 2.09
2	Family 01-05 M&F	Other Professional	94,254	$ 665,291	8,837	1,125	$ 75.29	$ 7.06
2	Family 01-05 M&F	Outpatient Hospital	94,254	$ 2,127,562	4,822	614	$ 441.21	$ 22.57
2	Family 01-05 M&F	PCP	94,254	$ 2,479,416	31,526	4,014	$ 78.65	$ 26.31
2	Family 01-05 M&F	Specialist	94,254	$ 434,398	4,282	545	$ 101.44	$ 4.61
2	Family 01-05 M&F	Vision	94,254	$ 190,411	959	122	$ 198.63	$ 2.02
2	Family 01-05 M&F	Rx	94,254	$ 1,600,718	42,380	5,396	$ 37.77	$ 16.98
2	Family 01-05 M&F	Behavioral Health - IP	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Behavioral Health - OP	94,254	$ 247,496	2,776	353	$ 89.15	$ 2.63
2	Family 01-05 M&F	Behavioral Health - Residential	94,254	$ -	-	-	$ -	$ -
2	Family 01-05 M&F	Behavioral Health - Other	94,254	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 06-20 F	DME/Supplies	82,972	$ 142,125	808	117	$ 175.99	$ 1.71
2	Family 06-20 F	Emergency Room	82,972	$ 1,224,505	2,831	409	$ 432.60	$ 14.76
2	Family 06-20 F	Emergency Transportation	82,972	$ 64,279	100	15	$ 640.94	$ 0.77
2	Family 06-20 F	EPSDT	82,972	$ 112,342	964	139	$ 116.59	$ 1.35
2	Family 06-20 F	Family Planning	82,972	$ 66,325	495	72	$ 133.99	$ 0.80
2	Family 06-20 F	FQHC/RHC	82,972	$ 315,642	2,879	416	$ 109.62	$ 3.80
2	Family 06-20 F	Home Health	82,972	$ 5,189	324	47	$ 16.04	$ 0.06
2	Family 06-20 F	Hospice	82,972	$ -	-	-	$ -	$ -
2	Family 06-20 F	Inpatient Hospital	82,972	$ 605,244	92	13	$ 6,570.92	$ 7.29
2	Family 06-20 F	Lab and Radiology	82,972	$ 141,529	5,784	837	$ 24.47	$ 1.71
2	Family 06-20 F	Non-Emergency Transportation - Ambulance	82,972	$ 2,060	5	1	$ 391.85	$ 0.02
2	Family 06-20 F	Other Care	82,972	$ 103,219	1,265	183	$ 81.60	$ 1.24
2	Family 06-20 F	Other Professional	82,972	$ 479,017	7,845	1,135	$ 61.06	$ 5.77
2	Family 06-20 F	Outpatient Hospital	82,972	$ 1,688,443	4,880	706	$ 345.96	$ 20.35
2	Family 06-20 F	PCP	82,972	$ 1,569,980	20,127	2,911	$ 78.00	$ 18.92
2	Family 06-20 F	Specialist	82,972	$ 348,090	3,791	548	$ 91.83	$ 4.20
2	Family 06-20 F	Vision	82,972	$ 300,747	2,084	301	$ 144.29	$ 3.62
2	Family 06-20 F	Rx	82,972	$ 2,729,461	45,431	6,571	$ 60.08	$ 32.90
2	Family 06-20 F	Behavioral Health - IP	82,972	$ 294,519	565	82	$ 521.04	$ 3.55
2	Family 06-20 F	Behavioral Health - OP	82,972	$ 1,309,909	18,043	2,609	$ 72.60	$ 15.79
2	Family 06-20 F	Behavioral Health - Residential	82,972	$ 81,583	319	46	$ 255.99	$ 0.98
2	Family 06-20 F	Behavioral Health - Other	82,972	$ 4,583	338	49	$ 13.57	$ 0.06

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and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 06-20 M	DME/Supplies	79,831	$ 107,395	689	104	$ 155.81	$ 1.35
2	Family 06-20 M	Emergency Room	79,831	$ 899,280	2,227	335	$ 403.84	$ 11.26
2	Family 06-20 M	Emergency Transportation	79,831	$ 48,424	73	11	$ 659.88	$ 0.61
2	Family 06-20 M	EPSDT	79,831	$ 119,248	1,034	155	$ 115.30	$ 1.49
2	Family 06-20 M	Family Planning	79,831	$ 62	1	0	$ 122.00	$ 0.00
2	Family 06-20 M	FQHC/RHC	79,831	$ 263,968	2,363	355	$ 111.70	$ 3.31
2	Family 06-20 M	Home Health	79,831	$ 1,461	83	12	$ 17.61	$ 0.02
2	Family 06-20 M	Hospice	79,831	$ -	-	-	$ -	$ -
2	Family 06-20 M	Inpatient Hospital	79,831	$ 623,413	67	10	$ 9,237.09	$ 7.81
2	Family 06-20 M	Lab and Radiology	79,831	$ 70,561	3,390	510	$ 20.82	$ 0.88
2	Family 06-20 M	Non-Emergency Transportation - Ambulance	79,831	$ 1,255	2	0	$ 815.80	$ 0.02
2	Family 06-20 M	Other Care	79,831	$ 152,369	1,536	231	$ 99.23	$ 1.91
2	Family 06-20 M	Other Professional	79,831	$ 389,404	6,281	944	$ 62.00	$ 4.88
2	Family 06-20 M	Outpatient Hospital	79,831	$ 1,208,057	3,033	456	$ 398.30	$ 15.13
2	Family 06-20 M	PCP	79,831	$ 1,279,738	16,488	2,478	$ 77.62	$ 16.03
2	Family 06-20 M	Specialist	79,831	$ 312,180	3,306	497	$ 94.42	$ 3.91
2	Family 06-20 M	Vision	79,831	$ 262,406	1,709	257	$ 153.52	$ 3.29
2	Family 06-20 M	Rx	79,831	$ 3,785,820	43,914	6,601	$ 86.21	$ 47.42
2	Family 06-20 M	Behavioral Health - IP	79,831	$ 196,347	386	58	$ 508.15	$ 2.46
2	Family 06-20 M	Behavioral Health - OP	79,831	$ 1,498,682	21,510	3,233	$ 69.67	$ 18.77
2	Family 06-20 M	Behavioral Health - Residential	79,831	$ 214,634	831	125	$ 258.14	$ 2.69
2	Family 06-20 M	Behavioral Health - Other	79,831	$ 5,714	259	39	$ 22.05	$ 0.07

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and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Family 21+ M&F	DME/Supplies	63,516	$ 407,099	2,585	488	$ 157.50	$ 6.41
2	Family 21+ M&F	Emergency Room	63,516	$ 2,642,054	4,495	849	$ 587.77	$ 41.60
2	Family 21+ M&F	Emergency Transportation	63,516	$ 105,440	207	39	$ 509.68	$ 1.66
2	Family 21+ M&F	EPSDT	63,516	$ -	-	-	$ -	$ -
2	Family 21+ M&F	Family Planning	63,516	$ 198,120	731	138	$ 270.97	$ 3.12
2	Family 21+ M&F	FQHC/RHC	63,516	$ 414,665	3,399	642	$ 121.99	$ 6.53
2	Family 21+ M&F	Home Health	63,516	$ 11,075	380	72	$ 29.16	$ 0.17
2	Family 21+ M&F	Hospice	63,516	$ 1,923	12	2	$ 160.21	$ 0.03
2	Family 21+ M&F	Inpatient Hospital	63,516	$ 3,140,567	412	78	$ 7,613.55	$ 49.45
2	Family 21+ M&F	Lab and Radiology	63,516	$ 497,592	18,481	3,492	$ 26.92	$ 7.83
2	Family 21+ M&F	Non-Emergency Transportation - Ambulance	63,516	$ 7,064	11	2	$ 662.54	$ 0.11
2	Family 21+ M&F	Other Care	63,516	$ 161,567	1,476	279	$ 109.48	$ 2.54
2	Family 21+ M&F	Other Professional	63,516	$ 832,190	11,573	2,186	$ 71.91	$ 13.10
2	Family 21+ M&F	Outpatient Hospital	63,516	$ 5,340,775	11,490	2,171	$ 464.80	$ 84.09
2	Family 21+ M&F	PCP	63,516	$ 2,701,836	27,417	5,180	$ 98.55	$ 42.54
2	Family 21+ M&F	Specialist	63,516	$ 1,227,702	10,235	1,934	$ 119.95	$ 19.33
2	Family 21+ M&F	Vision	63,516	$ 194,866	1,220	231	$ 159.70	$ 3.07
2	Family 21+ M&F	Rx	63,516	$ 5,825,467	99,166	18,735	$ 58.74	$ 91.72
2	Family 21+ M&F	Behavioral Health - IP	63,516	$ 270,129	581	110	$ 464.58	$ 4.25
2	Family 21+ M&F	Behavioral Health - OP	63,516	$ 1,039,186	14,185	2,680	$ 73.26	$ 16.36
2	Family 21+ M&F	Behavioral Health - Residential	63,516	$ 561,376	3,263	617	$ 172.02	$ 8.84
2	Family 21+ M&F	Behavioral Health - Other	63,516	$ 129,923	6,565	1,240	$ 19.79	$ 2.05

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Foster Care M&F	DME/Supplies	22,223	$ 131,518	619	334	$ 212.51	$ 5.92
2	Foster Care M&F	Emergency Room	22,223	$ 283,320	701	378	$ 404.38	$ 12.75
2	Foster Care M&F	Emergency Transportation	22,223	$ 27,023	44	24	$ 609.79	$ 1.22
2	Foster Care M&F	EPSDT	22,223	$ 85,575	755	408	$ 113.32	$ 3.85
2	Foster Care M&F	Family Planning	22,223	$ 9,641	78	42	$ 123.09	$ 0.43
2	Foster Care M&F	FQHC/RHC	22,223	$ 70,614	672	363	$ 105.07	$ 3.18
2	Foster Care M&F	Home Health	22,223	$ 14,045	438	237	$ 32.04	$ 0.63
2	Foster Care M&F	Hospice	22,223	$ -	-	-	$ -	$ -
2	Foster Care M&F	Inpatient Hospital	22,223	$ 516,028	77	42	$ 6,683.36	$ 23.22
2	Foster Care M&F	Lab and Radiology	22,223	$ 52,512	2,245	1,212	$ 23.39	$ 2.36
2	Foster Care M&F	Non-Emergency Transportation - Ambulance	22,223	$ 3,458	5	2	$ 761.84	$ 0.16
2	Foster Care M&F	Other Care	22,223	$ 270,742	3,574	1,930	$ 75.75	$ 12.18
2	Foster Care M&F	Other Professional	22,223	$ 117,867	1,588	858	$ 74.21	$ 5.30
2	Foster Care M&F	Outpatient Hospital	22,223	$ 564,864	1,407	760	$ 401.33	$ 25.42
2	Foster Care M&F	PCP	22,223	$ 671,525	8,627	4,659	$ 77.84	$ 30.22
2	Foster Care M&F	Specialist	22,223	$ 132,623	1,295	699	$ 102.41	$ 5.97
2	Foster Care M&F	Vision	22,223	$ 88,539	944	510	$ 93.78	$ 3.98
2	Foster Care M&F	Rx	22,223	$ 3,151,130	23,148	12,499	$ 136.13	$ 141.80
2	Foster Care M&F	Behavioral Health - IP	22,223	$ 194,313	363	196	$ 535.37	$ 8.74
2	Foster Care M&F	Behavioral Health - OP	22,223	$ 1,433,863	19,209	10,372	$ 74.65	$ 64.52
2	Foster Care M&F	Behavioral Health - Residential	22,223	$ 222,296	791	427	$ 281.08	$ 10.00
2	Foster Care M&F	Behavioral Health - Other	22,223	$ 2,673	62	34	$ 42.80	$ 0.12

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Katie Beckett 00-18 M&F	DME/Supplies	412	$ 314,037	1,064	30,982	$ 295.23	$ 762.22
2	Katie Beckett 00-18 M&F	Emergency Room	412	$ 11,919	20	596	$ 582.11	$ 28.93
2	Katie Beckett 00-18 M&F	Emergency Transportation	412	$ 638	1	43	$ 427.65	$ 1.55
2	Katie Beckett 00-18 M&F	EPSDT	412	$ 489	4	130	$ 109.76	$ 1.19
2	Katie Beckett 00-18 M&F	Family Planning	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	FQHC/RHC	412	$ 357	2	65	$ 160.71	$ 0.87
2	Katie Beckett 00-18 M&F	Home Health	412	$ 4,011,030	9,534	277,677	$ 420.73	$ 9,735.51
2	Katie Beckett 00-18 M&F	Hospice	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Inpatient Hospital	412	$ 293,970	14	421	$ 20,345.27	$ 713.52
2	Katie Beckett 00-18 M&F	Lab and Radiology	412	$ 610	43	1,256	$ 14.15	$ 1.48
2	Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Other Care	412	$ 28,369	249	7,252	$ 113.94	$ 68.86
2	Katie Beckett 00-18 M&F	Other Professional	412	$ 37,808	50	1,451	$ 758.98	$ 91.77
2	Katie Beckett 00-18 M&F	Outpatient Hospital	412	$ 65,515	76	2,200	$ 867.36	$ 159.02
2	Katie Beckett 00-18 M&F	PCP	412	$ 24,364	233	6,780	$ 104.67	$ 59.14
2	Katie Beckett 00-18 M&F	Specialist	412	$ 13,986	106	3,094	$ 131.67	$ 33.95
2	Katie Beckett 00-18 M&F	Vision	412	$ 1,963	10	289	$ 197.73	$ 4.77
2	Katie Beckett 00-18 M&F	Rx	412	$ 55,391	1,283	37,364	$ 43.18	$ 134.44
2	Katie Beckett 00-18 M&F	Behavioral Health - IP	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Behavioral Health - OP	412	$ 173	3	73	$ 68.58	$ 0.42
2	Katie Beckett 00-18 M&F	Behavioral Health - Residential	412	$ -	-	-	$ -	$ -
2	Katie Beckett 00-18 M&F	Behavioral Health - Other	412	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	Maternity	DME/Supplies	2,211	$ 126,479	890	4,829	$ 142.14	$ 57.20
2	Maternity	Emergency Room	2,211	$ 429,073	1,026	5,569	$ 418.12	$ 194.05
2	Maternity	Emergency Transportation	2,211	$ 72,373	66	356	$ 1,102.58	$ 32.73
2	Maternity	EPSDT	2,211	$ 361	3	18	$ 111.48	$ 0.16
2	Maternity	Family Planning	2,211	$ 247,541	556	3,019	$ 444.91	$ 111.95
2	Maternity	FQHC/RHC	2,211	$ 66,833	574	3,116	$ 116.42	$ 30.23
2	Maternity	Home Health	2,211	$ 881	47	254	$ 18.86	$ 0.40
2	Maternity	Hospice	2,211	$ -	-	-	$ -	$ -
2	Maternity	Inpatient Hospital	2,211	$ 7,099,810	2,124	11,527	$ 3,342.53	$ 3,210.88
2	Maternity	Lab and Radiology	2,211	$ 250,684	7,089	38,471	$ 35.36	$ 113.37
2	Maternity	Non-Emergency Transportation - Ambulance	2,211	$ 3,838	8	43	$ 486.48	$ 1.74
2	Maternity	Other Care	2,211	$ 96,421	289	1,569	$ 333.61	$ 43.61
2	Maternity	Other Professional	2,211	$ 541,194	3,698	20,069	$ 146.35	$ 244.75
2	Maternity	Outpatient Hospital	2,211	$ 1,338,372	6,166	33,463	$ 217.06	$ 605.28
2	Maternity	PCP	2,211	$ 4,250,509	15,925	86,425	$ 266.91	$ 1,922.28
2	Maternity	Specialist	2,211	$ 207,220	2,564	13,912	$ 80.83	$ 93.72
2	Maternity	Vision	2,211	$ 34,941	239	1,296	$ 146.32	$ 15.80
2	Maternity	Rx	2,211	$ -	-	-	$ -	$ -
2	Maternity	Behavioral Health - IP						
2	Maternity	Behavioral Health - OP						
2	Maternity	Behavioral Health - Residential						
2	Maternity	Behavioral Health - Other						

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	AABD 00-20 M&F	ALL	9,807	$ 9,858,022	51,368	62,855	$ 191.91	$ 1,005.20
2	AABD 21+ M&F	ALL	27,407	$ 38,102,924	301,781	132,133	$ 126.26	$ 1,390.26
2	AABD 21+ M&F-WWC	ALL	451	$ 1,063,397	4,510	119,992	$ 235.80	$ 2,357.86
2	CHIP M&F	ALL	107,941	$ 14,649,156	139,045	15,458	$ 105.36	$ 135.71
2	Family Under 1 M&F	ALL	32,855	$ 11,961,575	83,404	30,463	$ 143.42	$ 364.07
2	Family 01-05 M&F	ALL	94,254	$ 11,503,407	115,194	14,666	$ 99.86	$ 122.05
2	Family 06-20 F	ALL	82,972	$ 11,588,791	118,969	17,206	$ 97.41	$ 139.67
2	Family 06-20 M	ALL	79,831	$ 11,440,416	109,183	16,412	$ 104.78	$ 143.31
2	Family 21+ M&F	ALL	63,516	$ 25,710,617	217,884	41,165	$ 118.00	$ 404.79
2	Foster Care M&F	ALL	22,223	$ 8,044,170	66,643	35,986	$ 120.71	$ 361.97
2	Katie Beckett 00-18 M&F	ALL	412	$ 4,860,618	12,692	369,673	$ 382.96	$ 11,797.62
2	Maternity	ALL	2,211	$ 14,766,531	41,264	223,936	$ 357.86	$ 6,678.14
Total			**521,669**	**$ 163,549,624**	**1,261,937**	**29,028**	**$ 129.60**	**$ 313.51**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-B
Physical and Behavioral Health Databook, Rating Region 2

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
2	ALL	DME/Supplies	521,669	$ 3,961,180	19,851	457	$ 199.54	$ 7.59
2	ALL	Emergency Room	521,669	$ 10,801,233	25,692	591	$ 420.41	$ 20.71
2	ALL	Emergency Transportation	521,669	$ 880,249	1,357	31	$ 648.71	$ 1.69
2	ALL	EPSDT	521,669	$ 2,170,468	20,197	465	$ 107.46	$ 4.16
2	ALL	Family Planning	521,669	$ 556,704	2,156	50	$ 258.22	$ 1.07
2	ALL	FQHC/RHC	521,669	$ 2,543,746	22,510	518	$ 113.01	$ 4.88
2	ALL	Home Health	521,669	$ 4,701,888	21,403	492	$ 219.68	$ 9.01
2	ALL	Hospice	521,669	$ 174,658	1,191	27	$ 146.61	$ 0.33
2	ALL	Inpatient Hospital	521,669	$ 28,813,416	5,598	129	$ 5,147.40	$ 55.23
2	ALL	Lab and Radiology	521,669	$ 1,609,697	63,236	1,455	$ 25.46	$ 3.09
2	ALL	Non-Emergency Transportation - Ambulance	521,669	$ 52,124	84	2	$ 621.13	$ 0.10
2	ALL	Other Care	521,669	$ 2,144,311	20,665	475	$ 103.76	$ 4.11
2	ALL	Other Professional	521,669	$ 4,664,471	63,192	1,454	$ 73.81	$ 8.94
2	ALL	Outpatient Hospital	521,669	$ 23,398,727	53,343	1,227	$ 438.65	$ 44.85
2	ALL	PCP	521,669	$ 20,308,669	205,861	4,735	$ 98.65	$ 38.93
2	ALL	Specialist	521,669	$ 5,452,087	47,882	1,101	$ 113.86	$ 10.45
2	ALL	Vision	521,669	$ 1,685,033	10,646	245	$ 158.28	$ 3.23
2	ALL	Rx	521,669	$ 37,226,930	474,601	10,917	$ 78.44	$ 71.36
2	ALL	Behavioral Health - IP	521,669	$ 1,851,982	3,787	87	$ 489.01	$ 3.55
2	ALL	Behavioral Health - OP	521,669	$ 7,933,982	109,675	2,523	$ 72.34	$ 15.21
2	ALL	Behavioral Health - Residential	521,669	$ 1,325,891	6,633	153	$ 199.88	$ 2.54
2	ALL	Behavioral Health - Other	521,669	$ 1,292,177	82,375	1,895	$ 15.69	$ 2.48
Total			**521,669**	**$ 163,549,624**	**1,261,937**	**29,028**	**$ 129.60**	**$ 313.51**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 00-20 M&F	DME/Supplies	35,303	$ 2,704,086	8,259	2,807	$ 327.40	$ 76.60
1	AABD 00-20 M&F	Emergency Room	35,303	$ 743,766	2,204	749	$ 337.42	$ 21.07
1	AABD 00-20 M&F	Emergency Transportation	35,303	$ 93,227	185	63	$ 503.94	$ 2.64
1	AABD 00-20 M&F	EPSDT	35,303	$ 141,976	1,087	369	$ 130.66	$ 4.02
1	AABD 00-20 M&F	Family Planning	35,303	$ 11,983	115	39	$ 104.17	$ 0.34
1	AABD 00-20 M&F	FQHC/RHC	35,303	$ 145,295	1,140	387	$ 127.47	$ 4.12
1	AABD 00-20 M&F	Home Health	35,303	$ 3,127,933	9,501	3,230	$ 329.22	$ 88.60
1	AABD 00-20 M&F	Hospice	35,303	$ 29,821	173	59	$ 172.57	$ 0.84
1	AABD 00-20 M&F	Inpatient Hospital	35,303	$ 6,409,348	298	101	$ 21,499.47	$ 181.55
1	AABD 00-20 M&F	Lab and Radiology	35,303	$ 118,103	3,205	1,090	$ 36.85	$ 3.35
1	AABD 00-20 M&F	Non-Emergency Transportation - Ambulance	35,303	$ 2,687	7	2	$ 381.26	$ 0.08
1	AABD 00-20 M&F	Other Care	35,303	$ 1,070,976	5,586	1,899	$ 191.73	$ 30.34
1	AABD 00-20 M&F	Other Professional	35,303	$ 530,918	2,974	1,011	$ 178.51	$ 15.04
1	AABD 00-20 M&F	Outpatient Hospital	35,303	$ 3,503,565	6,836	2,324	$ 512.52	$ 99.24
1	AABD 00-20 M&F	PCP	35,303	$ 1,799,724	18,023	6,126	$ 99.86	$ 50.98
1	AABD 00-20 M&F	Specialist	35,303	$ 835,461	6,597	2,243	$ 126.64	$ 23.67
1	AABD 00-20 M&F	Vision	35,303	$ 156,212	663	225	$ 235.56	$ 4.42
1	AABD 00-20 M&F	Rx	35,303	$ 7,969,545	56,173	19,094	$ 141.87	$ 225.75
1	AABD 00-20 M&F	Behavioral Health - IP	35,303	$ 447,682	872	296	$ 513.56	$ 12.68
1	AABD 00-20 M&F	Behavioral Health - OP	35,303	$ 1,129,691	17,246	5,862	$ 65.51	$ 32.00
1	AABD 00-20 M&F	Behavioral Health - Residential	35,303	$ 163,209	783	266	$ 208.39	$ 4.62
1	AABD 00-20 M&F	Behavioral Health - Other	35,303	$ 81,250	4,051	1,377	$ 20.06	$ 2.30

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 21+ M&F	DME/Supplies	106,576	$ 3,908,382	19,510	2,197	$ 200.33	$ 36.67
1	AABD 21+ M&F	Emergency Room	106,576	$ 7,868,868	14,586	1,642	$ 539.49	$ 73.83
1	AABD 21+ M&F	Emergency Transportation	106,576	$ 1,008,988	3,393	382	$ 297.36	$ 9.47
1	AABD 21+ M&F	EPSDT	106,576	$ 131	1	0	$ 123.40	$ 0.00
1	AABD 21+ M&F	Family Planning	106,576	$ 73,360	454	51	$ 161.70	$ 0.69
1	AABD 21+ M&F	FQHC/RHC	106,576	$ 1,201,898	8,753	986	$ 137.31	$ 11.28
1	AABD 21+ M&F	Home Health	106,576	$ 1,624,160	20,315	2,287	$ 79.95	$ 15.24
1	AABD 21+ M&F	Hospice	106,576	$ 616,029	3,857	434	$ 159.70	$ 5.78
1	AABD 21+ M&F	Inpatient Hospital	106,576	$ 27,576,547	2,866	323	$ 9,622.94	$ 258.75
1	AABD 21+ M&F	Lab and Radiology	106,576	$ 1,369,263	40,732	4,586	$ 33.62	$ 12.85
1	AABD 21+ M&F	Non-Emergency Transportation - Ambulance	106,576	$ 33,687	105	12	$ 319.99	$ 0.32
1	AABD 21+ M&F	Other Care	106,576	$ 2,417,352	15,907	1,791	$ 151.96	$ 22.68
1	AABD 21+ M&F	Other Professional	106,576	$ 1,400,848	12,701	1,430	$ 110.29	$ 13.14
1	AABD 21+ M&F	Outpatient Hospital	106,576	$ 15,665,650	34,110	3,841	$ 459.27	$ 146.99
1	AABD 21+ M&F	PCP	106,576	$ 9,711,655	83,514	9,403	$ 116.29	$ 91.12
1	AABD 21+ M&F	Specialist	106,576	$ 5,441,306	35,214	3,965	$ 154.52	$ 51.06
1	AABD 21+ M&F	Vision	106,576	$ 658,420	2,935	330	$ 224.34	$ 6.18
1	AABD 21+ M&F	Rx	106,576	$ 39,957,794	421,916	47,506	$ 94.71	$ 374.92
1	AABD 21+ M&F	Behavioral Health - IP	106,576	$ 4,591,014	7,481	842	$ 613.73	$ 43.08
1	AABD 21+ M&F	Behavioral Health - OP	106,576	$ 3,153,116	46,460	5,231	$ 67.87	$ 29.59
1	AABD 21+ M&F	Behavioral Health - Residential	106,576	$ 2,718,732	17,654	1,988	$ 154.00	$ 25.51
1	AABD 21+ M&F	Behavioral Health - Other	106,576	$ 3,556,217	275,651	31,037	$ 12.90	$ 33.37

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 21+ M&F-WWC	DME/Supplies	1,109	$ 34,065	139	1,506	$ 244.70	$ 30.72
1	AABD 21+ M&F-WWC	Emergency Room	1,109	$ 49,534	77	829	$ 646.57	$ 44.67
1	AABD 21+ M&F-WWC	Emergency Transportation	1,109	$ 2,232	5	58	$ 416.93	$ 2.01
1	AABD 21+ M&F-WWC	EPSDT	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Family Planning	1,109	$ 750	4	39	$ 209.05	$ 0.68
1	AABD 21+ M&F-WWC	FQHC/RHC	1,109	$ 14,568	96	1,034	$ 152.44	$ 13.14
1	AABD 21+ M&F-WWC	Home Health	1,109	$ 3,366	190	2,054	$ 17.73	$ 3.04
1	AABD 21+ M&F-WWC	Hospice	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Inpatient Hospital	1,109	$ 336,210	39	419	$ 8,677.77	$ 303.17
1	AABD 21+ M&F-WWC	Lab and Radiology	1,109	$ 116,561	1,758	19,027	$ 66.29	$ 105.10
1	AABD 21+ M&F-WWC	Non-Emergency Transportation - Ambulance	1,109	$ -	-	-	$ -	$ -
1	AABD 21+ M&F-WWC	Other Care	1,109	$ 30,954	203	2,201	$ 152.18	$ 27.91
1	AABD 21+ M&F-WWC	Other Professional	1,109	$ 17,925	106	1,151	$ 168.56	$ 16.16
1	AABD 21+ M&F-WWC	Outpatient Hospital	1,109	$ 747,660	859	9,290	$ 870.86	$ 674.17
1	AABD 21+ M&F-WWC	PCP	1,109	$ 412,796	1,408	15,233	$ 293.23	$ 372.22
1	AABD 21+ M&F-WWC	Specialist	1,109	$ 321,307	591	6,399	$ 543.36	$ 289.73
1	AABD 21+ M&F-WWC	Vision	1,109	$ 6,568	59	642	$ 110.73	$ 5.92
1	AABD 21+ M&F-WWC	Rx	1,109	$ 177,134	3,693	39,963	$ 47.96	$ 159.72
1	AABD 21+ M&F-WWC	Behavioral Health - IP	1,109	$ 3,747	7	81	$ 502.48	$ 3.38
1	AABD 21+ M&F-WWC	Behavioral Health - OP	1,109	$ 19,284	252	2,724	$ 76.60	$ 17.39
1	AABD 21+ M&F-WWC	Behavioral Health - Residential	1,109	$ 6,361	32	350	$ 196.48	$ 5.74
1	AABD 21+ M&F-WWC	Behavioral Health - Other	1,109	$ 301	15	157	$ 20.68	$ 0.27

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	CHIP M&F	DME/Supplies	317,346	$ 562,576	2,993	113	$ 187.94	$ 1.77
1	CHIP M&F	Emergency Room	317,346	$ 2,712,890	9,164	347	$ 296.04	$ 8.55
1	CHIP M&F	Emergency Transportation	317,346	$ 121,177	298	11	$ 407.11	$ 0.38
1	CHIP M&F	EPSDT	317,346	$ 1,757,189	13,280	502	$ 132.32	$ 5.54
1	CHIP M&F	Family Planning	317,346	$ 87,770	708	27	$ 123.93	$ 0.28
1	CHIP M&F	FQHC/RHC	317,346	$ 1,357,979	10,476	396	$ 129.63	$ 4.28
1	CHIP M&F	Home Health	317,346	$ 122,856	611	23	$ 200.95	$ 0.39
1	CHIP M&F	Hospice	317,346	$ -	-	-	$ -	$ -
1	CHIP M&F	Inpatient Hospital	317,346	$ 2,143,553	287	11	$ 7,457.77	$ 6.75
1	CHIP M&F	Lab and Radiology	317,346	$ 319,504	13,371	506	$ 23.89	$ 1.01
1	CHIP M&F	Non-Emergency Transportation - Ambulance	317,346	$ 6,143	14	1	$ 425.11	$ 0.02
1	CHIP M&F	Other Care	317,346	$ 579,437	5,122	194	$ 113.12	$ 1.83
1	CHIP M&F	Other Professional	317,346	$ 1,208,062	17,449	660	$ 69.23	$ 3.81
1	CHIP M&F	Outpatient Hospital	317,346	$ 6,421,250	16,121	610	$ 398.31	$ 20.23
1	CHIP M&F	PCP	317,346	$ 5,769,581	73,856	2,793	$ 78.12	$ 18.18
1	CHIP M&F	Specialist	317,346	$ 1,410,568	15,865	600	$ 88.91	$ 4.44
1	CHIP M&F	Vision	317,346	$ 1,078,760	2,166	82	$ 498.04	$ 3.40
1	CHIP M&F	Rx	317,346	$ 12,795,955	143,493	5,426	$ 89.17	$ 40.32
1	CHIP M&F	Behavioral Health - IP	317,346	$ 630,526	1,311	50	$ 481.10	$ 1.99
1	CHIP M&F	Behavioral Health - OP	317,346	$ 3,751,795	67,645	2,558	$ 55.46	$ 11.82
1	CHIP M&F	Behavioral Health - Residential	317,346	$ 291,010	1,174	44	$ 247.81	$ 0.92
1	CHIP M&F	Behavioral Health - Other	317,346	$ 113,073	2,661	101	$ 42.49	$ 0.36

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family Under 1 M&F	DME/Supplies	106,184	$ 544,963	4,616	522	$ 118.06	$ 5.13
1	Family Under 1 M&F	Emergency Room	106,184	$ 2,024,821	10,900	1,232	$ 185.76	$ 19.07
1	Family Under 1 M&F	Emergency Transportation	106,184	$ 136,796	252	29	$ 541.78	$ 1.29
1	Family Under 1 M&F	EPSDT	106,184	$ 4,867,452	35,936	4,061	$ 135.45	$ 45.84
1	Family Under 1 M&F	Family Planning	106,184	$ 149	1	0	$ 143.37	$ 0.00
1	Family Under 1 M&F	FQHC/RHC	106,184	$ 849,867	6,282	710	$ 135.29	$ 8.00
1	Family Under 1 M&F	Home Health	106,184	$ 188,040	4,109	464	$ 45.77	$ 1.77
1	Family Under 1 M&F	Hospice	106,184	$ 11,438	70	8	$ 162.39	$ 0.11
1	Family Under 1 M&F	Inpatient Hospital	106,184	$ 19,806,111	3,896	440	$ 5,083.68	$ 186.53
1	Family Under 1 M&F	Lab and Radiology	106,184	$ 165,860	7,974	901	$ 20.80	$ 1.56
1	Family Under 1 M&F	Non-Emergency Transportation - Ambulance	106,184	$ 4,713	9	1	$ 528.40	$ 0.04
1	Family Under 1 M&F	Other Care	106,184	$ 1,212,661	3,287	372	$ 368.89	$ 11.42
1	Family Under 1 M&F	Other Professional	106,184	$ 650,692	7,766	878	$ 83.79	$ 6.13
1	Family Under 1 M&F	Outpatient Hospital	106,184	$ 2,656,398	10,187	1,151	$ 260.76	$ 25.02
1	Family Under 1 M&F	PCP	106,184	$ 6,333,898	69,103	7,809	$ 91.66	$ 59.65
1	Family Under 1 M&F	Specialist	106,184	$ 1,702,822	10,063	1,137	$ 169.22	$ 16.04
1	Family Under 1 M&F	Vision	106,184	$ 309,351	230	26	$ 1,346.01	$ 2.91
1	Family Under 1 M&F	Rx	106,184	$ 1,592,495	60,507	6,838	$ 26.32	$ 15.00
1	Family Under 1 M&F	Behavioral Health - IP	106,184	$ -	-	-	$ -	$ -
1	Family Under 1 M&F	Behavioral Health - OP	106,184	$ 1,920	20	2	$ 97.99	$ 0.02
1	Family Under 1 M&F	Behavioral Health - Residential	106,184	$ -	-	-	$ -	$ -
1	Family Under 1 M&F	Behavioral Health - Other	106,184	$ -	-	-	$ -	$ -

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 01-05 M&F	DME/Supplies	332,138	$ 484,653	3,518	127	$ 137.74	$ 1.46
1	Family 01-05 M&F	Emergency Room	332,138	$ 3,389,784	18,075	653	$ 187.54	$ 10.21
1	Family 01-05 M&F	Emergency Transportation	332,138	$ 151,061	359	13	$ 420.39	$ 0.45
1	Family 01-05 M&F	EPSDT	332,138	$ 3,109,607	23,305	842	$ 133.43	$ 9.36
1	Family 01-05 M&F	Family Planning	332,138	$ 149	1	0	$ 147.87	$ 0.00
1	Family 01-05 M&F	FQHC/RHC	332,138	$ 1,807,973	13,404	484	$ 134.88	$ 5.44
1	Family 01-05 M&F	Home Health	332,138	$ 158,300	802	29	$ 197.36	$ 0.48
1	Family 01-05 M&F	Hospice	332,138	$ -	-	-	$ -	$ -
1	Family 01-05 M&F	Inpatient Hospital	332,138	$ 2,975,100	384	14	$ 7,742.75	$ 8.96
1	Family 01-05 M&F	Lab and Radiology	332,138	$ 247,748	13,606	492	$ 18.21	$ 0.75
1	Family 01-05 M&F	Non-Emergency Transportation - Ambulance	332,138	$ 4,671	10	0	$ 450.86	$ 0.01
1	Family 01-05 M&F	Other Care	332,138	$ 642,901	6,053	219	$ 106.21	$ 1.94
1	Family 01-05 M&F	Other Professional	332,138	$ 1,511,578	17,374	628	$ 87.00	$ 4.55
1	Family 01-05 M&F	Outpatient Hospital	332,138	$ 7,187,521	20,057	725	$ 358.35	$ 21.64
1	Family 01-05 M&F	PCP	332,138	$ 7,584,858	96,390	3,483	$ 78.69	$ 22.84
1	Family 01-05 M&F	Specialist	332,138	$ 1,198,289	13,377	483	$ 89.58	$ 3.61
1	Family 01-05 M&F	Vision	332,138	$ 987,001	1,168	42	$ 845.18	$ 2.97
1	Family 01-05 M&F	Rx	332,138	$ 5,502,189	135,795	4,906	$ 40.52	$ 16.57
1	Family 01-05 M&F	Behavioral Health - IP	332,138	$ 1,973	3	0	$ 610.91	$ 0.01
1	Family 01-05 M&F	Behavioral Health - OP	332,138	$ 1,258,132	38,874	1,404	$ 32.36	$ 3.79
1	Family 01-05 M&F	Behavioral Health - Residential	332,138	$ -	-	-	$ -	$ -
1	Family 01-05 M&F	Behavioral Health - Other	332,138	$ 1,477	132	5	$ 11.18	$ 0.00

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 06-20 F	DME/Supplies	284,805	$ 375,241	2,488	105	$ 150.82	$ 1.32
1	Family 06-20 F	Emergency Room	284,805	$ 3,108,988	10,387	438	$ 299.31	$ 10.92
1	Family 06-20 F	Emergency Transportation	284,805	$ 129,150	400	17	$ 322.60	$ 0.45
1	Family 06-20 F	EPSDT	284,805	$ 832,229	6,476	273	$ 128.52	$ 2.92
1	Family 06-20 F	Family Planning	284,805	$ 320,966	2,204	93	$ 145.65	$ 1.13
1	Family 06-20 F	FQHC/RHC	284,805	$ 1,142,430	8,706	367	$ 131.22	$ 4.01
1	Family 06-20 F	Home Health	284,805	$ 93,924	525	22	$ 179.03	$ 0.33
1	Family 06-20 F	Hospice	284,805	$ -	-	-	$ -	$ -
1	Family 06-20 F	Inpatient Hospital	284,805	$ 2,217,133	262	11	$ 8,455.36	$ 7.78
1	Family 06-20 F	Lab and Radiology	284,805	$ 424,984	15,990	674	$ 26.58	$ 1.49
1	Family 06-20 F	Non-Emergency Transportation - Ambulance	284,805	$ 5,466	14	1	$ 381.93	$ 0.02
1	Family 06-20 F	Other Care	284,805	$ 349,504	3,598	152	$ 97.15	$ 1.23
1	Family 06-20 F	Other Professional	284,805	$ 965,083	13,785	581	$ 70.01	$ 3.39
1	Family 06-20 F	Outpatient Hospital	284,805	$ 4,828,027	14,700	619	$ 328.43	$ 16.95
1	Family 06-20 F	PCP	284,805	$ 4,604,608	59,354	2,501	$ 77.58	$ 16.17
1	Family 06-20 F	Specialist	284,805	$ 1,048,916	11,861	500	$ 88.43	$ 3.68
1	Family 06-20 F	Vision	284,805	$ 940,699	2,098	88	$ 448.42	$ 3.30
1	Family 06-20 F	Rx	284,805	$ 10,017,659	138,283	5,826	$ 72.44	$ 35.17
1	Family 06-20 F	Behavioral Health - IP	284,805	$ 1,124,843	2,300	97	$ 489.17	$ 3.95
1	Family 06-20 F	Behavioral Health - OP	284,805	$ 4,299,862	67,099	2,827	$ 64.08	$ 15.10
1	Family 06-20 F	Behavioral Health - Residential	284,805	$ 405,719	1,659	70	$ 244.54	$ 1.42
1	Family 06-20 F	Behavioral Health - Other	284,805	$ 120,008	3,531	149	$ 33.98	$ 0.42

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 06-20 M	DME/Supplies	272,407	$ 372,520	2,476	109	$ 150.47	$ 1.37
1	Family 06-20 M	Emergency Room	272,407	$ 2,488,674	8,224	362	$ 302.59	$ 9.14
1	Family 06-20 M	Emergency Transportation	272,407	$ 119,056	335	15	$ 355.27	$ 0.44
1	Family 06-20 M	EPSDT	272,407	$ 897,938	7,026	309	$ 127.81	$ 3.30
1	Family 06-20 M	Family Planning	272,407	$ 82	1	0	$ 151.89	$ 0.00
1	Family 06-20 M	FQHC/RHC	272,407	$ 934,280	7,177	316	$ 130.18	$ 3.43
1	Family 06-20 M	Home Health	272,407	$ 99,863	838	37	$ 119.22	$ 0.37
1	Family 06-20 M	Hospice	272,407	$ -	-	-	$ -	$ -
1	Family 06-20 M	Inpatient Hospital	272,407	$ 1,503,141	169	7	$ 8,914.60	$ 5.52
1	Family 06-20 M	Lab and Radiology	272,407	$ 203,359	8,388	369	$ 24.25	$ 0.75
1	Family 06-20 M	Non-Emergency Transportation - Ambulance	272,407	$ 3,153	7	0	$ 448.55	$ 0.01
1	Family 06-20 M	Other Care	272,407	$ 414,830	4,141	182	$ 100.18	$ 1.52
1	Family 06-20 M	Other Professional	272,407	$ 782,822	10,707	472	$ 73.11	$ 2.87
1	Family 06-20 M	Outpatient Hospital	272,407	$ 4,058,049	10,208	450	$ 397.52	$ 14.90
1	Family 06-20 M	PCP	272,407	$ 3,885,738	50,039	2,204	$ 77.65	$ 14.26
1	Family 06-20 M	Specialist	272,407	$ 942,275	11,312	498	$ 83.30	$ 3.46
1	Family 06-20 M	Vision	272,407	$ 880,641	1,635	72	$ 538.69	$ 3.23
1	Family 06-20 M	Rx	272,407	$ 14,074,780	131,490	5,792	$ 107.04	$ 51.67
1	Family 06-20 M	Behavioral Health - IP	272,407	$ 706,713	1,528	67	$ 462.63	$ 2.59
1	Family 06-20 M	Behavioral Health - OP	272,407	$ 5,180,498	101,842	4,486	$ 50.87	$ 19.02
1	Family 06-20 M	Behavioral Health - Residential	272,407	$ 518,015	2,621	115	$ 197.61	$ 1.90
1	Family 06-20 M	Behavioral Health - Other	272,407	$ 94,743	3,248	143	$ 29.17	$ 0.35

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Family 21+ M&F	DME/Supplies	224,680	$ 1,060,176	7,059	377	$ 150.18	$ 4.72
1	Family 21+ M&F	Emergency Room	224,680	$ 8,872,055	19,647	1,049	$ 451.58	$ 39.49
1	Family 21+ M&F	Emergency Transportation	224,680	$ 342,354	1,032	55	$ 331.61	$ 1.52
1	Family 21+ M&F	EPSDT	224,680	$ 1,137	6	0	$ 196.08	$ 0.01
1	Family 21+ M&F	Family Planning	224,680	$ 1,015,267	4,004	214	$ 253.56	$ 4.52
1	Family 21+ M&F	FQHC/RHC	224,680	$ 1,319,949	9,820	524	$ 134.41	$ 5.87
1	Family 21+ M&F	Home Health	224,680	$ 118,349	2,190	117	$ 54.04	$ 0.53
1	Family 21+ M&F	Hospice	224,680	$ 6,806	42	2	$ 161.57	$ 0.03
1	Family 21+ M&F	Inpatient Hospital	224,680	$ 8,602,672	1,150	61	$ 7,482.85	$ 38.29
1	Family 21+ M&F	Lab and Radiology	224,680	$ 1,766,308	49,085	2,622	$ 35.98	$ 7.86
1	Family 21+ M&F	Non-Emergency Transportation - Ambulance	224,680	$ 9,812	27	1	$ 367.81	$ 0.04
1	Family 21+ M&F	Other Care	224,680	$ 796,121	6,940	371	$ 114.72	$ 3.54
1	Family 21+ M&F	Other Professional	224,680	$ 1,843,207	21,825	1,166	$ 84.45	$ 8.20
1	Family 21+ M&F	Outpatient Hospital	224,680	$ 12,774,997	34,633	1,850	$ 368.87	$ 56.86
1	Family 21+ M&F	PCP	224,680	$ 8,818,283	94,622	5,054	$ 93.19	$ 39.25
1	Family 21+ M&F	Specialist	224,680	$ 3,829,112	29,570	1,579	$ 129.50	$ 17.04
1	Family 21+ M&F	Vision	224,680	$ 795,910	1,964	105	$ 405.22	$ 3.54
1	Family 21+ M&F	Rx	224,680	$ 17,376,111	318,799	17,027	$ 54.50	$ 77.34
1	Family 21+ M&F	Behavioral Health - IP	224,680	$ 816,912	1,540	82	$ 530.44	$ 3.64
1	Family 21+ M&F	Behavioral Health - OP	224,680	$ 3,474,391	50,785	2,712	$ 68.41	$ 15.46
1	Family 21+ M&F	Behavioral Health - Residential	224,680	$ 1,321,658	7,979	426	$ 165.63	$ 5.88
1	Family 21+ M&F	Behavioral Health - Other	224,680	$ 253,179	15,051	804	$ 16.82	$ 1.13

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Foster Care M&F	DME/Supplies	82,203	$ 899,235	3,397	496	$ 264.73	$ 10.94
1	Foster Care M&F	Emergency Room	82,203	$ 960,254	3,290	480	$ 291.86	$ 11.68
1	Foster Care M&F	Emergency Transportation	82,203	$ 75,990	184	27	$ 412.59	$ 0.92
1	Foster Care M&F	EPSDT	82,203	$ 468,158	3,679	537	$ 127.26	$ 5.70
1	Foster Care M&F	Family Planning	82,203	$ 39,861	312	46	$ 127.62	$ 0.48
1	Foster Care M&F	FQHC/RHC	82,203	$ 257,606	2,060	301	$ 125.03	$ 3.13
1	Foster Care M&F	Home Health	82,203	$ 504,876	3,572	521	$ 141.33	$ 6.14
1	Foster Care M&F	Hospice	82,203	$ 2,035	12	2	$ 172.06	$ 0.02
1	Foster Care M&F	Inpatient Hospital	82,203	$ 3,782,006	224	33	$ 16,860.74	$ 46.01
1	Foster Care M&F	Lab and Radiology	82,203	$ 160,186	7,129	1,041	$ 22.47	$ 1.95
1	Foster Care M&F	Non-Emergency Transportation - Ambulance	82,203	$ 9,050	20	3	$ 454.62	$ 0.11
1	Foster Care M&F	Other Care	82,203	$ 802,052	7,875	1,150	$ 101.85	$ 9.76
1	Foster Care M&F	Other Professional	82,203	$ 318,062	3,460	505	$ 91.91	$ 3.87
1	Foster Care M&F	Outpatient Hospital	82,203	$ 1,897,257	6,206	906	$ 305.73	$ 23.08
1	Foster Care M&F	PCP	82,203	$ 1,931,697	23,495	3,430	$ 82.22	$ 23.50
1	Foster Care M&F	Specialist	82,203	$ 448,780	4,253	621	$ 105.53	$ 5.46
1	Foster Care M&F	Vision	82,203	$ 283,324	2,284	333	$ 124.05	$ 3.45
1	Foster Care M&F	Rx	82,203	$ 10,112,318	89,116	13,009	$ 113.47	$ 123.02
1	Foster Care M&F	Behavioral Health - IP	82,203	$ 1,434,795	3,164	462	$ 453.52	$ 17.45
1	Foster Care M&F	Behavioral Health - OP	82,203	$ 6,666,763	132,183	19,296	$ 50.44	$ 81.10
1	Foster Care M&F	Behavioral Health - Residential	82,203	$ 1,396,617	3,887	567	$ 359.28	$ 16.99
1	Foster Care M&F	Behavioral Health - Other	82,203	$ 148,204	4,888	714	$ 30.32	$ 1.80

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Katie Beckett 00-18 M&F	DME/Supplies	412	$ 314,037	1,064	30,982	$ 295.23	$ 762.22
1	Katie Beckett 00-18 M&F	Emergency Room	412	$ 11,919	20	596	$ 582.11	$ 28.93
1	Katie Beckett 00-18 M&F	Emergency Transportation	412	$ 638	1	43	$ 427.65	$ 1.55
1	Katie Beckett 00-18 M&F	EPSDT	412	$ 489	4	130	$ 109.76	$ 1.19
1	Katie Beckett 00-18 M&F	Family Planning	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	FQHC/RHC	412	$ 357	2	65	$ 160.71	$ 0.87
1	Katie Beckett 00-18 M&F	Home Health	412	$ 4,011,030	9,534	277,677	$ 420.73	$ 9,735.51
1	Katie Beckett 00-18 M&F	Hospice	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Inpatient Hospital	412	$ 293,970	14	421	$ 20,345.27	$ 713.52
1	Katie Beckett 00-18 M&F	Lab and Radiology	412	$ 610	43	1,256	$ 14.15	$ 1.48
1	Katie Beckett 00-18 M&F	Non-Emergency Transportation - Ambulance	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Other Care	412	$ 28,369	249	7,252	$ 113.94	$ 68.86
1	Katie Beckett 00-18 M&F	Other Professional	412	$ 37,808	50	1,451	$ 758.98	$ 91.77
1	Katie Beckett 00-18 M&F	Outpatient Hospital	412	$ 65,515	76	2,200	$ 867.36	$ 159.02
1	Katie Beckett 00-18 M&F	PCP	412	$ 24,364	233	6,780	$ 104.67	$ 59.14
1	Katie Beckett 00-18 M&F	Specialist	412	$ 13,986	106	3,094	$ 131.67	$ 33.95
1	Katie Beckett 00-18 M&F	Vision	412	$ 1,963	10	289	$ 197.73	$ 4.77
1	Katie Beckett 00-18 M&F	Rx	412	$ 55,391	1,283	37,364	$ 43.18	$ 134.44
1	Katie Beckett 00-18 M&F	Behavioral Health - IP	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Behavioral Health - OP	412	$ 173	3	73	$ 68.58	$ 0.42
1	Katie Beckett 00-18 M&F	Behavioral Health - Residential	412	$ -	-	-	$ -	$ -
1	Katie Beckett 00-18 M&F	Behavioral Health - Other	412	$ -	-	-	$ -	$ -

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and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	Maternity	DME/Supplies	6,649	$ 446,302	3,761	6,789	$ 118.66	$ 67.13
1	Maternity	Emergency Room	6,649	$ 1,221,430	3,039	5,485	$ 401.94	$ 183.71
1	Maternity	Emergency Transportation	6,649	$ 123,469	384	694	$ 321.12	$ 18.57
1	Maternity	EPSDT	6,649	$ 825	6	11	$ 131.81	$ 0.12
1	Maternity	Family Planning	6,649	$ 982,129	2,254	4,068	$ 435.72	$ 147.72
1	Maternity	FQHC/RHC	6,649	$ 411,650	2,917	5,265	$ 141.11	$ 61.92
1	Maternity	Home Health	6,649	$ 27,582	542	978	$ 50.88	$ 4.15
1	Maternity	Hospice	6,649	$ -	-	-	$ -	$ -
1	Maternity	Inpatient Hospital	6,649	$ 23,093,051	6,971	12,581	$ 3,312.91	$ 3,473.41
1	Maternity	Lab and Radiology	6,649	$ 939,380	20,507	37,013	$ 45.81	$ 141.29
1	Maternity	Non-Emergency Transportation - Ambulance	6,649	$ 7,466	21	38	$ 351.58	$ 1.12
1	Maternity	Other Care	6,649	$ 354,347	1,604	2,895	$ 220.88	$ 53.30
1	Maternity	Other Professional	6,649	$ 2,094,209	8,503	15,346	$ 246.30	$ 314.99
1	Maternity	Outpatient Hospital	6,649	$ 3,138,141	19,083	34,443	$ 164.45	$ 472.01
1	Maternity	PCP	6,649	$ 11,546,969	38,402	69,311	$ 300.69	$ 1,736.77
1	Maternity	Specialist	6,649	$ 1,128,937	8,695	15,694	$ 129.84	$ 169.80
1	Maternity	Vision	6,649	$ 56,353	236	426	$ 238.66	$ 8.48
1	Maternity	Rx	6,649	$ -	-	-	$ -	$ -
1	Maternity	Behavioral Health - IP						
1	Maternity	Behavioral Health - OP						
1	Maternity	Behavioral Health - Residential						
1	Maternity	Behavioral Health - Other						

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	AABD 00-20 M&F	ALL	35,303	$ 31,216,458	145,979	49,620	$ 213.84	$ 884.24
1	AABD 21+ M&F	ALL	106,576	$ 134,553,416	1,068,116	120,265	$ 125.97	$ 1,262.51
1	AABD 21+ M&F-WWC	ALL	1,109	$ 2,301,323	9,533	103,156	$ 241.40	$ 2,075.13
1	CHIP M&F	ALL	317,346	$ 43,241,653	398,067	15,052	$ 108.63	$ 136.26
1	Family Under 1 M&F	ALL	106,184	$ 43,060,447	235,208	26,581	$ 183.07	$ 405.53
1	Family 01-05 M&F	ALL	332,138	$ 38,204,966	402,690	14,549	$ 94.87	$ 115.03
1	Family 06-20 F	ALL	284,805	$ 37,355,441	365,720	15,409	$ 102.14	$ 131.16
1	Family 06-20 M	ALL	272,407	$ 38,161,170	363,409	16,009	$ 105.01	$ 140.09
1	Family 21+ M&F	ALL	224,680	$ 75,214,765	677,770	36,199	$ 110.97	$ 334.76
1	Foster Care M&F	ALL	82,203	$ 32,599,124	304,691	44,479	$ 106.99	$ 396.57
1	Katie Beckett 00-18 M&F	ALL	412	$ 4,860,618	12,692	369,673	$ 382.96	$ 11,797.62
1	Maternity	ALL	6,649	$ 45,572,242	116,926	211,040	$ 389.75	$ 6,854.49
Total			**1,763,163**	**$ 526,341,622**	**4,100,801**	**27,910**	**$ 128.35**	**$ 298.52**

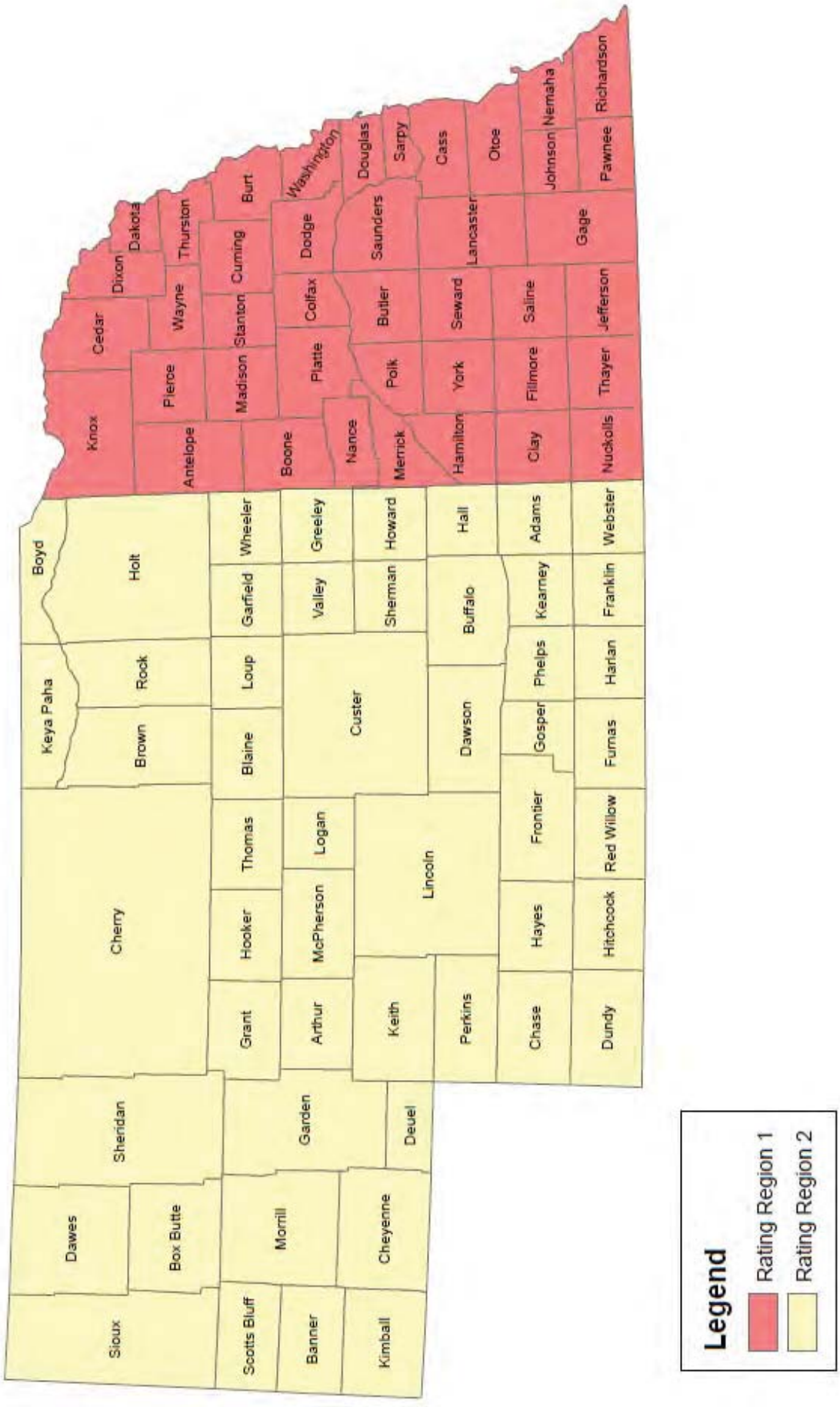
*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 10-A
Physical and Behavioral Health Databook, Rating Region 1

			Base Data*					
Rating Region	COA	COS	MMs	Dollars	Units	Util/K	Unit Cost	PMPM
1	ALL	DME/Supplies	1,763,163	$ 11,706,234	59,281	403	$ 197.47	$ 6.64
1	ALL	Emergency Room	1,763,163	$ 33,452,981	99,614	678	$ 335.83	$ 18.97
1	ALL	Emergency Transportation	1,763,163	$ 2,304,139	6,831	46	$ 337.31	$ 1.31
1	ALL	EPSDT	1,763,163	$ 12,077,130	90,806	618	$ 133.00	$ 6.85
1	ALL	Family Planning	1,763,163	$ 2,532,465	10,057	68	$ 251.81	$ 1.44
1	ALL	FQHC/RHC	1,763,163	$ 9,443,852	70,834	482	$ 133.32	$ 5.36
1	ALL	Home Health	1,763,163	$ 10,080,279	52,728	359	$ 191.17	$ 5.72
1	ALL	Hospice	1,763,163	$ 666,128	4,155	28	$ 160.33	$ 0.38
1	ALL	Inpatient Hospital	1,763,163	$ 98,738,842	16,560	113	$ 5,962.45	$ 56.00
1	ALL	Lab and Radiology	1,763,163	$ 5,831,868	181,789	1,237	$ 32.08	$ 3.31
1	ALL	Non-Emergency Transportation - Ambulance	1,763,163	$ 86,849	235	2	$ 369.23	$ 0.05
1	ALL	Other Care	1,763,163	$ 8,699,506	60,566	412	$ 143.64	$ 4.93
1	ALL	Other Professional	1,763,163	$ 11,361,214	116,700	794	$ 97.35	$ 6.44
1	ALL	Outpatient Hospital	1,763,163	$ 62,944,030	173,076	1,178	$ 363.68	$ 35.70
1	ALL	PCP	1,763,163	$ 62,424,170	608,437	4,141	$ 102.60	$ 35.40
1	ALL	Specialist	1,763,163	$ 18,321,760	147,504	1,004	$ 124.21	$ 10.39
1	ALL	Vision	1,763,163	$ 6,155,202	15,448	105	$ 398.45	$ 3.49
1	ALL	Rx	1,763,163	$ 119,631,370	1,500,548	10,213	$ 79.73	$ 67.85
1	ALL	Behavioral Health - IP	1,763,163	$ 9,758,207	18,204	124	$ 536.04	$ 5.53
1	ALL	Behavioral Health - OP	1,763,163	$ 28,935,624	522,406	3,555	$ 55.39	$ 16.41
1	ALL	Behavioral Health - Residential	1,763,163	$ 6,821,319	35,792	244	$ 190.58	$ 3.87
1	ALL	Behavioral Health - Other	1,763,163	$ 4,368,453	309,229	2,105	$ 14.13	$ 2.48
Total			**1,763,163**	**$ 526,341,622**	**4,100,801**	**27,910**	**$ 128.35**	**$ 298.52**

*Base Data represents FY14 and FY15 for Physical Health
and Behavioral Health services (BH Foster Care represents FY15 only)

Attachment 9
Rating Regions



Attachment 8 redacted

Adult Core Measures
Cervical Cancer Screening (CCS)
Chlamydia Screening in Women (CHL)
Flu Vaccinations for Adults Age 18 and Older (FVA)
Screening for Clinical Depression and Follow-Up Plan (CDF)
Breast Cancer Screening (BCS)
Adult Body Mass Index Assessment (ABA)
PC-01: Elective Delivery (PC01)
PC-03: Antenatal Steroids (PC03)
Prenatal & Postpartum Care: Postpartum Care Rate (PPC)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
Antidepressant Medication Management (AMM)
Follow-Up After Hospitalization for Mental Illness (FUH)
Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
Controlling High Blood Pressure (CBP)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)*
PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)
PQI 08: Heart Failure Admission Rate (PQI08)
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
PQI 15: Asthma in Younger Adults Admission Rate (PQI15)
Plan All-Cause Readmissions (PCR)
HIV Viral Load Suppression (HVL)
Annual Monitoring for Patients on Persistent Medications (MPM)
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)
Child Core Measures
Child and Adolescents' Access to Primary Care Practitioners (CAP)
Chlamydia Screening in Women (CHL)
Childhood Immunization Status (CIS)
Well-Child Visits in the First 15 Months of Life (W15)
Immunizations for Adolescents (IMA)
Developmental Screening in the First Three Years of Life (DEV)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Human Papillomavirus Vaccine for Female Adolescents (HPV)
Adolescent Well-Care Visit (AWC)
Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
PC-02: Cesarean Section (PC02)
Live Births Weighing Less Than 2,500 Grams (LBW)
Frequency of Ongoing Prenatal Care (FPC)
Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)
Follow-Up After Hospitalization for Mental Illness (FUH)
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)
Medication Management for People with Asthma (MMA)
Ambulatory Care – Emergency Department (ED) Visits (AMB)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)
HEDIS Measures
Comprehensive Diabetes Care
Medication Management for People with Asthma (Adults)
Lead Screening in Children
Appropriate Testing for Children with Pharyngitis
Race/Ethnicity Diversity of Membership
Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Pharmacotherapy Management of COPD Exacerbation
Use of Appropriate Medications for People with Asthma
Annual Monitoring for Patients with Persistent Medications
Adults' Access to Preventative/Ambulatory Health Services
Antibiotic Utilization
Frequency of Ongoing Prenatal Care
Timeliness of Prenatal Care

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

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

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

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

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

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

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

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

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

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

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

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

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

Marketing Plan	Submit plan detailing proposed marketing activities and materials as described in Section IV.G - Member Marketing.	120 days prior to contract start date
Welcome Packet Contents	Submit welcome packet materials as described in Section IV.F - Member Services and Education	120 days prior to contract start date
Welcome Call Script	Submit script for member welcome calls as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Member Education Plan	Submit member education plan as described in Section IV.F - Member Services and Education.	120 days prior to contract start date
Enrollment Broker	Submit policies and procedures for receiving file submissions from the Enrollment Broker as described in Section IV.B - Eligibility and Enrollment.	120 days prior to contract start date
90 Days Prior to Contract Start Date	**Description**	**Due Date**
Provider Network List	Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network.	90 days prior to contract start date
Provider Network Sufficiency Attestation	Submit data and analysis attesting to the sufficiency of the MCOs network as described in Section IV.I - Provider Network.	90 days prior to contract start date
Subcontracts	Submit all subcontracts for the provision of any services for prior review and approval as described in Section IV.K - Subcontracting.	90 days prior to contract start date
MCO Provider Website	As detailed in Section IV.J - Provider Services, the MCO's provider website is considered marketing material and must be submitted for review and approval.	90 days prior to contract start date

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

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

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

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

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

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

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

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

Attachment 4
Patient-Centered Medical Home Standards

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

1. Practice utilizes written plan for patient communication including accommodations for hearing and visually-impaired individuals and English as a second language patients.

2. Practice utilizes written materials for patients that explain the features and essential information related to the medical home; materials are published in primary language(s) of the community.

3. Practice utilizes patient-centered care planning (includes patient's goals, values, and priorities) to engage patients in their care. Practice plan can include a written after visit summary outlining future care plan and given to patient at every visit.

4. Practice utilizes reminder/notification system for health care services such as appointments, preventive care, preparation information for upcoming visits, follow-up with patients regarding periodic tests or screening, and for missed appointments.

5. Practice provides patient education and self-management tools and support for patients, families, and caregivers.

6. Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.

7. Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

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

1. Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.

2. Practice provides care coordination and supports family participation in care including providing connections to community resources.

3. Practice utilizes a system to maintain and review a list of patient's medications.

4. Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient, plus follows up after referrals, specialist care, and other consultations.

5. Practice utilizes a patient registry.

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

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

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

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

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

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

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

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

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

4. Practice provides day-of-call appointments.

5. Practice utilizes written practice standards for patient access.

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

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

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

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

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

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

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

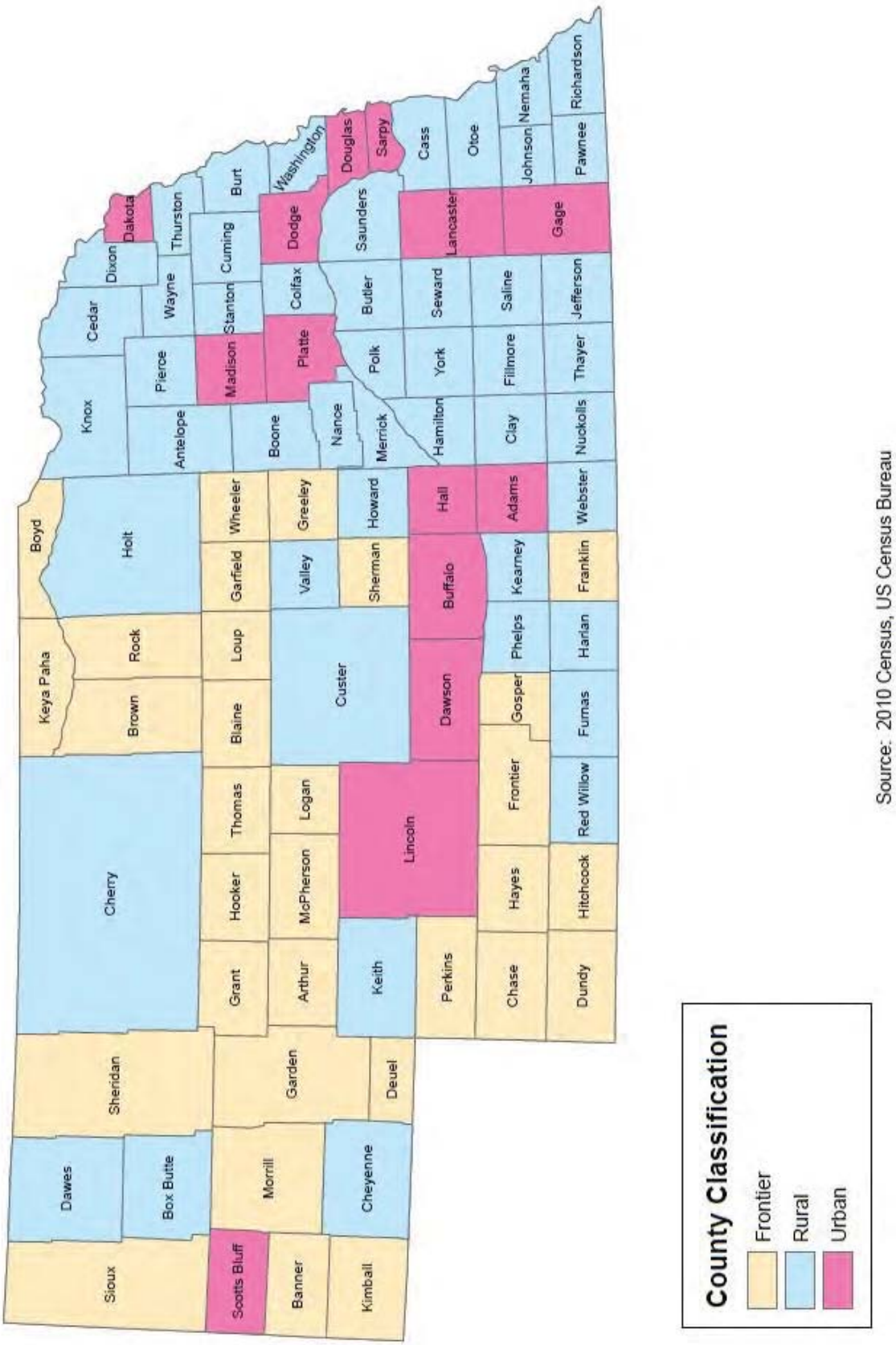
3. Practice develops an operational quality improvement plan for the practice with at least one focus area.

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

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

Attachment 3

Nebraska Counties Classified by Urban/Rural/Frontier Status



Source: 2010 Census, US Census Bureau

Attachment 2
Access Standards

Appointment Availability Access Standards

1. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

2. Urgent care must be available the same day and be provided by the PCP or as arranged by the MCO.

3. Non-urgent sick care must be available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation.

4. Family planning services must be available within seven calendar days.

5. Non-urgent, preventive care must be available within 4 weeks.

6. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

7. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

8. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

9. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the member must be seen within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.

Geographic Access Standards

1. The MCO must, at a minimum, contract with two PCPs within 30 miles of the personal residences of members 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.

2. The MCO must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.

3. The MCO must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to members (other than by mail order) to ensure convenient access to covered drugs.

    a. In urban counties, a network retail pharmacy must be available within five miles of 90% of members' personal residences.

    b. In rural counties, a network retail pharmacy must be available within 15 miles of 70% of members' personal residences.

    c. In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of members' personal residences.

4. The MCO must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC.

5. The MCO must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

6. The classification of counties according to urban, rural, and frontier status is included as Attachment 3, with classifications based upon data from the most recent U.S. Census.

Attachment 1 redacted

State of Nebraska (State Purchasing Bureau)

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5151 Z1	**October 21, 2015**
OPENING DATE AND TIME	PROCUREMENT CONTACT
December 22, 2015 2:00 p.m. Central Time	**Michelle Thompson / Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5151 Z1 for the purpose of selecting a qualified contractor to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services.

The State of Nebraska intends to award a minimum of two (2) and a maximum of three (3) MCO contracts for the scope of work as described in Section IV. A. Program Description through Y. Termination of MCO Contract. One of the awarded contracts will also include the scope of work as described in Section IV. Z. FFS Claims Management and Processing.

Written questions for the first round of questions are due no later than November 2, 2015. Written questions for the second round of questions are due no later than November 23, 2015. Questions should be submitted via e-mail to as.materielpurchasing@nebraska.gov or may be sent by facsimile to (402) 471-2089.

The First Pre-Proposal Conference will be held on October 26, 2015 from 1:00 PM – 5:00 PM CST at Nebraska State Office Building, 301 Centennial Mall South, Lower Level, Conference Room A, Lincoln, Nebraska 68508. Bidders may call into the First Pre-Proposal Conference by utilizing the conference access number: (888) 820-1398 and attendee code: 8559164#.

The Second Pre-Proposal Conference will be held at the discretion of the State. If conducted, information will be provided at a later date.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

Contractor hereby grants permission to the State of Nebraska and/or its agencies to reprint or republish any and all copyrighted documents related to Contractor's response to this Request for Proposal, and any and all figures, illustrations, photographs, charts, and other supplementary material on a website accessible by the public pursuant to Neb. Rev. Stat. §84-602.02. This waiver does not apply to proprietary information properly submitted in a separate sealed, package clearly marked "Proprietary."

Contractor represents and warrants that the contents of this response to Request for Proposal and all figures, illustrations, photographs, charts, and other supplementary material herein are original and do not libel anyone or infringe upon any patent, copyright, proprietary right, or any other right whatsoever of any other party. Contractor represents and warrants that Contractor has full power and authority to execute this Copyright Release and to grant the State of Nebraska and/or its agencies the right granted herein.

Contractor agrees to indemnify, defend, and hold harmless the State of Nebraska and/or its agencies against any and all claims, suits, and/or judgments, including costs, expenses, damages, and reasonable legal fees based upon and arising from Contractor's violation of the rights of others and/or by reason of a breach of any of the foregoing warranties.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat §73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

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

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

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GLOSSARY OF ACRONYMS

ACT: Assertive community treatment

BCP: Business continuity plan

CAC: Clinical Advisory Committee

CAH: Critical access hospital

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CAP: Corrective action plan

CCAA: Comprehensive child and adolescent assessment

CCC: Children with chronic conditions

CLIA: Clinical Laboratory Improvement Amendments

CFR: Code of Federal Regulations

CHCQM: Certified in health care quality management

CHIP: Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Reauthorization Act

CM: Care management

CME: Confirmation of MCO enrollment

CMS: Centers for Medicare & Medicaid Services

COA: Certificate of Authority

CPHQ: Certified professional in health care quality

CPT: Current procedural terminology

CTA: Community treatment aide

DBH: Division of Behavioral Health

DHHS: Nebraska Department of Health and Human Services

DME: Durable medical equipment

DRP: Disaster recovery plan

DUR: Drug utilization review

ECM: Electronic claims management

EOB: Explanation of benefits

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment

EQR: External quality review

EQRO: External quality review organization

Federal DHHS: U.S. Department of Health and Human Services

FFP: Federal financial participation

FFS: Fee-for-service

FQHC: Federally qualified health center

FWA: Fraud, waste, and abuse

GAO: General Accounting Office

HCBS: Home and community based services

HEDIS: Healthcare Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

HIPF: Health insurance providers' fee

HMO: Health maintenance organization

IHS: Indian Health Service

IS: Information systems

I/T/U: Indian Health Services/Tribal 638/Urban Indian Health

IVR: Interactive voice response

LTSS: Long-term services and supports

MAC: Maximum allowable costs

MCO: Managed care organization

MFPAU: Medicaid Fraud and Patient Abuse Unit

MH: Mental health

MHPAEA: Mental Health Parity and Addiction Equity Act

MLR: Medical loss ratio

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

MTM: Medication therapy management

NAC: Nebraska Administrative Code

NCPCP: National Council for Prescription Drug Programs

NCQA: National Committee for Quality Assurance

NMPI: Nebraska Medicaid Program Integrity Unit

NPI: National provider identifier

OEM: Original equipment manufacturer

PBM: Pharmacy benefit manager

PCMH: Patient-centered medical home

PCP: Primary care provider

PDL: Preferred drug list

PHI: Protected health information

PIP: Performance improvement project

PMPM: Per member per month

PPC: Provider preventable condition

QAPI: Quality assurance and performance improvement

QAPIC: Quality Assurance and Performance Improvement Committee

QI: Quality improvement

QM: Quality management

QPP: Quality performance program

RFP: Request for proposal

RHC: Rural health clinic

SDF: Software development firm

SHCN: Special health care needs

SHD: Systems help desk

SMI: Serious mental illness

SUD: Substance use disorder

TPL: Third party liability

TTY/TDD: Teletypewriter and telecommunications device for the deaf

UM: Utilization management

UR: Utilization review

VPN: Virtual private network

WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

GLOSSARY OF TERMS

ACCESSNebraska: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

Action: Defined in this RFP as the:

9. Denial or limited authorization of a requested service, including the type or level of service.
10. Reduction, suspension, or termination of a previously authorized service.
11. Denial, in whole or in part, of payment for a service.
12. Failure of a MCO to act within timeframes provided in this RFP or as directed by the State.
13. Failure of a MCO to process grievances, appeals, or expedited appeals within required timeframes.

Addendum: Something to be added or deleted to an existing document; a supplement.

Adjudicate: To pay or deny a claim.

Adjustment: Modification to an adjudicated claim.

Administrative cap: The upper limit of the rate a MCO may spend on administrative expenses.

Administrative expense rate: The percentage of qualifying revenue a MCO may spend on administrative expenses. Administrative expense rate equals the costs that would have been incurred in the contract year in the absence of any related-party relationship.

Advance directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Nebraska Constitution.

Agent/Representative: A person authorized to act on behalf of another.

Allowable quality improvement expense: A MCO's expenditure on qualified quality improvement activities described in Attachment 15 - Medical Loss Ratio Requirements of this RFP.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appeal: A request for review of an action.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Auto assignment: The process by which an enrollee, who does not select a MCO or PCP within a predetermined length of time during enrollment activities is automatically assigned to a MCO and PCP.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of a proposal, and do not improve a bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer: In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: An offer submitted by a vendor in a response to a RFP.

Bidder: A vendor who submits an offer bid in response to a RFP.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.
Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Capitation payment: A monthly payment by the State to a MCO on behalf of each member of a MCO for the provision of covered services under the contract. Payment is made regardless of whether any particular member receives services during the period covered by the payment.

Care management: A collaborative process of assessment, planning, facilitation, coordination, and advocacy for options and services that the MCO must conduct to meet an individual's health needs, through communication and provision of available resources to promote quality, cost-effective outcomes.

Children's Health Insurance Program (CHIP): Nebraska's CHIP program is a combination Medicaid CHIP state with a Medicaid CHIP expansion program under Title XXI called "Kid's Connection". Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the federal poverty level. The separate CHIP program established July 19, 2012 provides Medicaid coverage for the unborn children of pregnant women who are otherwise not Medicaid eligible.

Choice counseling: The provision of information about available MCO's and unbiased decision support for selection of an MCO by the enrollment broker for Medicaid enrollees.

Clean claim: A claim, received by a MCO for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the MCO. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claim: A bill for services, a line item of service, or all services for one member within a bill.

Cold-call marketing: Any unsolicited personal contact by a MCO with a potential enrollee for the purpose of marketing.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Complaint: See grievance.

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

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of a contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Core benefits and services: The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that must be provided by a MCO to members enrolled in the MCO.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice about those products

or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of a written solicitation or contract.

Disenroll: See Disenrollment, below.

Disenrollment: A change in the status of a member from being enrolled with a specific MCO to being enrolled with a different MCO, or a change from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Dispensing fee: The fee paid by a MCO to reimburse the overhead and labor expense incurred by pharmacy providers, and the professional services provided by a pharmacist when dispensing a prescription.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the licensed software that will provide the State with sufficient information to operate, diagnose, and maintain the licensed software properly, safely, and efficiently.

Drug encounter: Submission by a MCO of prescriptions billed by a pharmacy or medical professionals.

Earned hold-back: The portion of the hold-back a MCO may keep based upon MLTC's determination of the MCO's results compared with identified performance measures.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

Emergency services: Covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

Encounter data: Line-level utilization and expenditure data for services furnished to members through a MCO.

Enrollee: An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in the Nebraska Medical Assistance Program.

Enrollment: The process of an enrollee selecting a MCO.

Enrollment broker: The State's contracted entity for choice counseling and enrollment activities.

Enrollment file: A proprietary data file provided by the State to a MCO. It is the basis for monthly payments to the MCO.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals.

Extension: Continuance of a contract for a specified duration by agreement of the parties beyond the original Contract Period. Not to be confused with "renewal period".

Family planning services: Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

Federally qualified MCO: An MCO that CMS has determined is a qualified MCO under Section 1310(d) of the Public Health Services Act.

Fee-for-service: A method of provider reimbursement based on payments for each service rendered.

Forfeited hold-back: The portion of the hold-back a MCO must forfeit, based upon MLTC's determination of the MCO's results compared with identified performance measures. Forfeited hold-back may also be referred to as unearned hold-back.

Formulary: A list maintained by a MCO giving details of medications payable by the MCO's health plan.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Generally accepted actuarial principles: The common set of actuarial standards, as determined by the American Academy of Actuaries.

Grievance: A written or verbal expression of dissatisfaction about any matter other than an action.

Health care professional: A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician's assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed and certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insurance providers fee: As required by Section 9010 of the Patient Protection and Affordable Care Act (ACA), the fee imposed on each covered entity engaged in the business of providing health insurance for United States health risks.

Health risk screening: A health questionnaire, used to provide individuals with an evaluation of their health risks and quality of life.

Health risk assessment: A more detailed assessment for those members who have been deemed to potentially qualify for care management services. The health risk assessment is used to collect information on a member's health status that includes, but is not limited to, member demographics, personal and family medical history, and lifestyle.

Hold-back: The portion of the MCO's revenue that the MCO must reserve in the reinvestment holding account and may potentially earn based upon MLTC's determination of the MCO's results on identified performance measures.

Hold-back account: The account a MCO must establish for the purpose of reserving the hold-back.

Information system(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data that may include digitized audio and video and documents, as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling or facilitating a business process or related transaction.

Insolvency: A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Liquidated damages: Damages that may be assessed whenever a MCO, its providers, and/or subcontractor fail to achieve certain performance standards and other items defined in this contract.

Long-term services and supports: Specific Medicaid-covered services including intermediate care facility services for individuals with developmental disabilities, any institutional long-term care or nursing facility services at a custodial level of care, services provided via a Home and Community Based Waiver program, Targeted Case Management, or Medicaid State Plan Personal Assistance Services.

Managed Care Organization (MCO): A private entity that contracts with MLTC to provide benefits and services to Nebraska Medicaid enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Nebraska Department of Insurance with respect to licensure and financial solvency, and with respect to its products and services offered pursuant to the HERITAGE HEALTH is regulated by the Nebraska Department of Health and Human Services.

Mandatory/Must: Required, compulsory, or obligatory.

Marketing: Any communication from a MCO to a Medicaid enrollee who is not enrolled in that entity that can reasonably be interpreted as intended to influence the enrollee to enroll in that particular MCO or either to not enroll in or to disenroll from another MCO.

Marketing materials: Materials that are produced in any medium, by or on behalf of the MCO, and can reasonably be interpreted as intended to market to potential enrollees.
May: Discretionary, permitted; used to express possibility.

Meaningful use: Using certified electronic health records technology in a meaningful way, as established in the Health Information Technology for Economic and Clinical Health Act.

Medicaid fraud: Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Medical incentive bonuses: Payments made by a MCO to providers and other unrelated risk sharing entities to share savings.

Medical loss ratio (MLR): The percentage of qualifying revenue (for the risk corridor and MLR calculations) spent on covered services for members and allowable QI expenses under this contract.

Medical necessity: Health care services and supplies that are medically appropriate and:
1. Necessary to meet the basic health needs of the member.
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her physician.
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. No more intensive level of service than can be safely provided.

Member: A Medicaid enrollee who is currently enrolled with a specific MCO.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See mandatory/must.

National Drug Code (NDC): The universal product identifier for human drugs.

Nebraska Medicaid Program (NE Medicaid or Medicaid): NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services (DHHS).

Net qualified medical expense (for the medical loss ratio): The sum of:
1. Claims incurred
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
3. Medical incentive bonuses
4. Reinsurance premiums less reinsurance recoveries
5. Activities that improve health care quality, per 45 CFR 158.150
6. Less related-party medical margin

Net qualified medical expense (for the risk corridor): The sum of:
1. Claims incurred
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
3. Medical incentive bonuses
4. Reinsurance premiums less reinsurance recoveries
5. Less related-party medical margin

Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses include:

1. Direct administration: customer service, enrollment, medical management, claims administration, etc.
2. Indirect administration: accounting, actuarial, legal, human resources, etc.
3. Net cost of reinsurance: reinsurance premium less projected reinsurance recoveries. Net cost of related party reinsurance is excluded.

Non-QI administrative expense rate: Non-QI Administrative Expenses divided by Qualifying Revenue.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.
Patient-centered medical home (PCMH): The Center for Medical Home Improvement defines PCMH as a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.

Patient centeredness: Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care. Patient centeredness focuses on the patient, not the illness, and is supported by good provider-patient relations.

Peer review: A process of evaluating work completed by practitioners in the same professional field.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that a Contractor fulfills any and all obligations under a contract.

Post stabilization care services: Covered services, related to an emergency medical condition, that are provided after an enrollee/member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e), to improve or resolve the enrollee's/member's condition.

Provider-preventable condition: Preventable healthcare-acquired or other provider-preventable conditions and events identified by MLTC for non-payment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient, or the wrong surgical procedure performed on a patient.

Potential enrollee: A Medicaid recipient who is subject to mandatory enrollment with an HMO, but is not yet a member of a specific MCO.

Practitioner: A Medicaid enrolled provider who is licensed, registered, or certified by MLTC to practice in the State.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Prepaid inpatient health plan (PIHP): As defined by 44 NAC Sections 4701 to 4727, and 42 CFR 438.2, a PIHP is and entity that:
1. Provides medical services to enrollees under contract with MLTC on the basis of prepaid capitation payments or other payment arrangements that do not use Medicaid State Plan payment rates.
2. Provides, arranges for, or otherwise has responsibility for, the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract.

Preferred drug list (PDL): A list maintained by MLTC, in partnership with the State Pharmaceutical and Therapeutics Committee, that indicates whether drugs are preferred or non-preferred by the State and therefore also by the MCO under the terms of this RFP.

Primary care provider (PCP): A medical professional chosen by or assigned to the member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing under the supervision of a physician who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.

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

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

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

Proposal: See Bid/Proposal.

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

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

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

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

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

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

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

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

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

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

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

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

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

Related-party administrative expense: Fees paid by a MCO, or any of its subsidiaries, to a related party such as a parent organization. Such fees are not considered in the calculation of administrative expense under this contract.

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

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

Release Date: The date of public release of the written solicitation to seek offers

Renewal Period: An optional contract period subsequent to the original contract period, for a specified duration, and with previously agreed-to terms and conditions. Not to be confused with an extension.

Representative: Includes an agent, an officer of a corporation or association, a trustee, executor or administrator of an estate, or any other person legally empowered to act for another.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to ensure good faith performance.

Responsive bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Restricted services: A method used by the State to limit the medical services of a client who has been determined to be abusing or inappropriately utilizing services provided by HERITAGE HEALTH.

Risk contract: A contract under which the contractor: (1) assumes risk for the cost of the services covered under the contract; and (2) incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk corridor: A risk sharing mechanism in which the State a MCO share in both profits and losses under a contract outside of a predetermined threshold amount, so that after an initial corridor in which the MCO is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses and receives a portion of any additional profits.

Risk corridor calculation: The computation of a MCO's profit or loss by MLTC's actuary, as a percentage of the aggregate of qualifying revenue for the MCO and related parties, including parent and subsidiary companies and risk-bearing parties under a contract. The calculation ignores revenue taxes, non-operating income, and any forfeited hold-back.

Risk Corridor payment: Payment made by MLTC to a MCO to compensate the MCO for losses greater than 3%, as determined by the risk corridor calculation.

SCRIPT: A standard promulgated by the National Council for Prescription Drug Programs (NCPDP) for the electronic transmittal of prescription information in the United States.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Social determinants of health: Conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Solvency: The minimum standard of financial health for a MCO, where assets exceed liabilities and timely payment requirements can be met.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Solicitation: The process of notifying prospective bidders that the State wishes to receive proposals for furnishing services. The process may consist of public advertising, posting notices, or mailing RFPs or a RFP announcement letter to prospective bidders.

Specialty drug: A drug not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or which has a minimum of two (2) of the following characteristics:

1. Requires inventory management controls, including but not limited to, unique storage specifications, short shelf life, and special handling.
2. Must be administered, infused, or injected by a health care professional.
3. Is indicated primarily for the treatment or prevention of:
    a. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer, or rheumatoid arthritis.
    b. A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States.
4. The total monthly cost is $10,000 or more.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

State: The State of Nebraska or Nebraska, as the context may require.

State fair hearing: A request by a member or physician to appeal a decision made by a MCO, addressed to the State.

State share: A portion of funds originally contributed by the State, rather than the Federal government, to the operation of the Medicaid program.

Subcontractor: Any organization or person who provides a function or service for a MCO specifically related to securing or fulfilling the MCO's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. Any obligation that may still be executory for either party is discharged, but any right based on prior breach or performance survives.

Third-party resource: Any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a member.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Value-added services: Those services a MCO provides in addition to a service covered under this contract because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to a Contractor by the State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require a vendor to cure. Two reports or more may be cause for immediate termination, at the sole discretion of the State, which right is not waived by any particular instance in which it is not exercised.

Waiver of enrollment: A change in the status of a member from being considered mandatory for participation in managed care to being ineligible for participation in managed care.

Will: See Shall/Will/Must

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 5151 Z1 for the purpose of selecting a qualified Contractor to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. Any resulting contract is not an exclusive contract to furnish the services provided for in this Request for Proposal, and does not preclude the purchase of similar services from other sources.

A contract resulting from this Request for Proposal will be issued approximately for a period of five (5) years effective the date of award. The contract has the option to be renewed for two (2) additional one (1) year periods as mutually agreed upon by all parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Contractor and the State of Nebraska.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	October 21, 2015
2.	Last day to submit "Notification of Intent to Attend Pre-Proposal Conference"	October 23, 2015
3.	First Pre-Proposal Conference Location: Nebraska State Office Building 301 Centennial Mall South Lower Level, Conference Room A Lincoln, NE 68508 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 8559164#	October 26, 2015 1:00 – 5:00 PM Central Time
4.	Last day to submit First Round of written questions	November 2, 2015
5.	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6.	Second Pre-Proposal Conference (if needed) Location: Lincoln, NE *Room and specific time to be announced at a later date. This will be held at the option of the state.*	November 19, 2015
7.	Last day to submit Second Round written questions	November 23, 2015
8.	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
9.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time
10.	Review for conformance of mandatory requirements	December 22, 2015
11.	Evaluation period	January 6, 2016 – January 22, 2016
12.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
13.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	January 29, 2016
14.	Contract finalization period	January 29, 2016 – February 29, 2016
15.	Contract award	March 1, 2016
16.	Contractor start date	January 1, 2017

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name: Michelle Thompson / Teresa Fleming
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508

Telephone: 402-471-6500
Facsimile: 402-471-2089
E-Mail: as.materielpurchasing@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules, and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. CUSTOMER SERVICE

In addition to any specified service requirements contained in this agreement, the Contractor agrees and understands that satisfactory customer service is required. Contractor will develop or provide technology and business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation. Contractor, its employees, Sub-Contractors, and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.

D. COMMUNICATION WITH STATE STAFF AND EVALUATORS

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the Contractor, contact regarding this project between potential Contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal. Bidders shall not have any communication with, or attempt to communicate with or influence in any way, any evaluator involved in this RFP.

Once a Contractor is preliminarily selected, as documented in the intent to contract, that Contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a Contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;
2. contacts made pursuant to any pre-existing contracts or obligations;
3. State staff and/or Contractor staff present at the Pre-Proposal Conference when recognized by the State Purchasing Bureau staff facilitating the meeting for the purpose of addressing questions; and
4. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5151 Z1; Medicaid Managed Care Program Questions". It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Michelle Thompson / Teresa Fleming, showing the total number of pages transmitted, and clearly marked "RFP Number 5151 Z1; Medicaid Managed Care Program Questions".

It is recommended that Bidders submit questions sequentially numbered, include the RFP reference and page number using the following format.

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

F. PRE-PROPOSAL CONFERENCE

A pre-proposal conference will be held on the date, time, and location shown in the Schedule of Events. Bidders will have an opportunity to ask questions at the conference to assist in the clarification and understanding of the Request for Proposal requirements. The State will make every reasonable attempt to answer those questions before the end of the conference. Bidders attending the pre-proposal meeting may submit further questions in writing for questions which the bidder requires an official written response as shown in the Schedule of Events.

Written answers to written questions along with a list of conference attendees will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events. Verbal responses provided during the pre-proposal meeting shall not be binding on the State of Nebraska.

1. NOTIFICATION OF INTENT TO ATTEND PRE-PROPOSAL CONFERENCE

Notification of attendance should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivery or US mail by the date shown in the Schedule of Events. Potential bidders should utilize the "Notification of Intent to Attend Pre-Proposal Conference" (see Form B) that accompanies this document to the contact person shown on the cover page of the Request for Proposal Form. This form should be filled out in its entirety and returned no later than the date shown in the Schedule of Events.

G. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

H. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling, and review by the State.

To facilitate the proposal evaluation process, one (1) original of the entire proposal should be submitted. Proposals must be submitted by the proposal due date and time. **A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials**. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the Request for Proposal number and be sent to the specified address. Please note that the address label should appear as specified in Section II part A on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The Request for Proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that the proposal will be rejected.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

The Technical Proposal should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The State has proposed page limitations as set forth in Attachment 19 – Proposal Statements and Questions.

I. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time, and location shown in the Schedule of Events. Proposals will be available for viewing by those present at the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website.

J. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic, or any other reason(s).

K. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

L. EVALUATION OF PROPOSALS

All responses to this Request for Proposal which fulfill all mandatory requirements will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview shall include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of bidder performance on prior contracts;
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract; and

2. Technical Approach.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a bid in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

a. Documentation from the United States Armed Forces confirming service;
b. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
c. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
d. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will become public information at the time of the Request for Proposal opening. Evaluation criteria and a list of respondents will be posted to the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing.html Evaluation criteria will not be released prior to the proposal opening.

M. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not be published.

Prior to award, bidders are advised that only the point of contact indicated on the front cover of this Request for Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State, or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

Any contact, or attempted contact, with an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions may be taken.

N. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Section III Terms and Conditions;
3. Corporate Overview; and
4. Technical Approach.

O. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects. The State may use a third-party to conduct reference checks.

Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: financial stability of the company, project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the reference would rehire the firm or individual. Only top scoring bidders may receive reference checks, and negative references may eliminate bidders from consideration for award.

P. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders should be authorized to transact business in the State of Nebraska. All bidders are expected to comply with all Nebraska Secretary of State Registration requirements. It is the responsibility of the bidder to comply with any registration requirements pertaining to types of business entities (e.g. person, partnership, foreign or domestic limited liability company, association, or foreign or domestic corporation or other type of business entity). The bidder who is the recipient of an Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its current (within ninety (90) calendar days), valid Certificate of Good Standing or Letter of Good Standing; or in the case of a sole proprietorship, provide written documentation of sole proprietorship. This must be accomplished prior to the award of the contract. Construction Contractors are expected to meet all applicable requirements of the Nebraska Contractor Registration Act and provide a current, valid certificate of registration. Further, all bidders shall comply with any and all other applicable Nebraska statutes regarding transacting business in the State of Nebraska. Bidders should submit the above certification(s) with their bid.

If a bank is registered with the Office of Comptroller of Currency, it is not required to register with the State. However, the Office of Comptroller of Currency does have a certificate of good standing/registration. The bank could provide that for verification. (Optional)

Q. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response**.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to

award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

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

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Sub-Contractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Sub-Contractor(s). The Contractor is also responsible for ensuring Sub-Contractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Sub-Contractor to commence work on any Sub-Contract until all similar insurance required of the Sub-Contractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

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

1. WORKERS' COMPENSATION INSURANCE

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

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

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

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

3. REINSURANCE

a. The MCO must file all contracts of reinsurance, or a summary of the plan of self-insurance.

b. All reinsurance agreements or summaries of plans of self-insurance must be filed with MLTC and must remain in full force and effect for a minimum of 30 calendar days following written notice by registered mail of cancellation by either party. Pursuant to the Health Maintenance Organization Act, Neb. Rev. Stat. §44-3292 et seq. and other relevant laws.

c. The MCO must maintain reinsurance agreements throughout the contract period, including any extension(s) or renewal(s). The MCO must provide prior notification to MLTC of its intent to purchase or modify reinsurance protection for any members enrolled in the MCO.

d. The MCO must provide to MLTC the risk analyses, assumptions, cost estimates, and rationales supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related-party relationship must be specifically disclosed.

4. INSURANCE COVERAGE AMOUNTS REQUIRED

a. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. COMMERCIAL GENERAL LIABILITY

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. COMMERCIAL AUTOMOBILE LIABILITY

Bodily Injury/Property Damage $1,000,000 combined single limit

d. UMBRELLA/EXCESS LIABILITY

Over Primary Insurance $5,000,000 per occurrence

e. ERRORS AND OMISSIONS $10,000,000, per occurrence

f. CYBER LIABILITY

Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties
$10,000,000 each occurrence / aggregate

g. SUBROGRATION WAIVER

"Waiver of Subrogation on the Worker's Compensation in favor of the State of Nebraska."

h. LIABILITY WAIVER

"The State of Nebraska, Certificate holder, is an additionally insured, primary & noncontributory on the General Liability."

5. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

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

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

9. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

10. The Contractor shall agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Sub-Contractor's services, the Sub-Contractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Sub-Contractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Sub-Contractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Sub-Contractor selected to perform work on the project.

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

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

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

9. any and all employment taxes and/or other payroll withholding;
10. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
11. damages incurred by Contractor's employees within the scope of their duties under the contract;
12. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
13. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project for a period of two years after the contract implementation date.

L. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

N. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

P. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

S. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

V. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Sub-Contractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

X. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

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

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

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

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor.

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

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

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

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

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

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

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

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

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

a. if directed to do so by statute;

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

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

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

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

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

g. Contractor intentionally discloses confidential information;

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

i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or

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

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

AA. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

BB. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

DD. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV Project Description and Scope of Work.

EE. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor shall not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor shall be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor shall obtain a performance bond in an amount equal to $50,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to

nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;

b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;

c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;

d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and

e. The Contractor shall reimburse MLTC for expenses exceeding the performance bond amount.

FF. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

GG. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

HH. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not

limited to those kept by the Contractor, its employees, agents, assigns, successors, and Sub-Contractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Sub-Contractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Sub-Contractors to the extent that those sub-contracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

II. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

JJ. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Sub-Contractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

KK. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, or a pro-rated value.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, that this RFP must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to this RFP that are required to bring Nebraska in compliance with federal Medicaid law shall be deemed part of the scope of the requested bid.

LL. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

MM. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

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

NN. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All non-proprietary or confidential information as defined by Law **WILL BE POSTED FOR PUBLIC VIEWING**.

OO. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

PP. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

QQ. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Price information is provided under Section IV.P MCO Reimbursement.

RR. BEST AND FINAL OFFER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State will compile the final scores for all parts of each proposal. The award may be granted to the highest scoring responsive and responsible bidder. Alternatively, the highest scoring bidder or bidders may be requested to submit best and final offers. If best and final offers are requested by the State and submitted by the bidder, they will be evaluated (using the stated criteria), scored, and ranked by the Evaluation Committee. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Sub-Contractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

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

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

3. PERSONNEL

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

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. §81-15,159.

ZZ. POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

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

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

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all sub-contracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

EEE. LICENSE/SERVICE OR OTHER AGREEMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Any License/Service or other such agreements which the bidder may want the State to consider must be submitted with the bid. Any License/Service or other such agreements submitted to the State post bid opening may result in

the bid being rejected in its entirety. Any such agreement, if agreed to by the State, will be considered an addendum to the contract. Any terms and conditions contained in any such accepted agreement (addendum) must not conflict with or alter the State's Terms and Conditions (Terms and Conditions) as contained in the RFP and finalized in the contract. In the event of any conflict between the Terms and Conditions and any addendum the Terms and Conditions will prevail.

The State reserves the right to reject any submitted addendum and considers the submission of any such addendum to be a proposed alteration of the Terms and Conditions.

This clause does not apply to any third party license or service agreements.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Request for Proposal.

A. PROGRAM DESCRIPTION

1. Description of Current Program

a. The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC). DHHS is comprised of six (6) divisions:

i. The Division of Behavioral Health provides funding, oversight, and technical assistance to the six (6) local behavioral health regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services.

ii. The Division of Children and Family Services administers child welfare, adult protective services, economic support programs, and the youth rehabilitation and treatment centers.

iii. The Division of Developmental Disabilities administers publicly-funded community-based disability services. The Division also operates several sites that provide services for individuals with developmental disabilities.

iv. MLTC administers the Medicaid program, which provides health care services to eligible elderly and disabled individuals, and low income pregnant women, children, and parents. The Division also administers non-institutional home and community-based services for qualified individuals, the aged, adults and children with disabilities, and infants and toddlers with special needs.

v. The Division of Public Health is responsible for preventive and community health programs and services. It also regulates and licenses health-related professionals, health care facilities, and services.

vi. The Division of Veterans' Homes oversees the State Veterans' Homes located in Bellevue, Norfolk, Grand Island and Scottsbluff.

b. Nebraska Medicaid currently provides health care coverage for approximately 239,000 individuals each month at an annual cost of approximately $1.8 billion. Attachment 1 – Medicaid Enrollees by County, State FY 2015 summarizes the number of Medicaid enrollees by county.

c. Heritage Health, implemented in July 1995, includes approximately 189,000 individuals enrolled in physical health managed care and approximately 229,000 individuals enrolled in behavioral health managed care. Those individuals who are enrolled in behavioral health managed care, but not physical health managed care, receive their physical health services from the Nebraska Medical Assistance Program under a fee-for-service (FFS) reimbursement model.

d. Heritage Health is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates a 1915(b) waiver in order to require special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits Nebraska Medicaid to operate the behavioral health managed care program.

e. Heritage Health currently includes:

i. Physical health managed care provided, through risk-comprehensive contracts that are fully-capitated and require the contracted entity to be a MCO or health insuring organization. "Comprehensive" means that the contracted entity is at financial risk to provide all the services in the core benefits package.

ii. Behavioral health managed care provided through a risk contract which is not comprehensive, but is fully-capitated, and requires that the managed care entity be a prepaid inpatient health plan (PIHP).

iii. Physical health managed care currently provided through:

a) Two (2) MCO networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.

b) Two (2) MCO networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.

iv. Behavioral health managed care provided through one statewide PIHP network.

f. MLTC currently contracts with vendors to perform the following services for the Heritage Health:

i. physical health managed care services
ii. behavioral health managed care services
iii. enrollment broker services
iv. external quality review services
v. actuarial services
vi. pharmacy benefit management services

g. With implementation of this contract, notable changes in the managed care program will include:

i. Integration of physical and behavioral health managed care through a minimum of two (2) and a maximum of three (3) MCO contracts for all 93 counties in the State of Nebraska.

ii. Inclusion of pharmacy services in the core benefit package and the MCO capitation rate, at a date to be determined by MLTC.

iii. Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for managed care physical health services.

iv. Expansion of enrollment broker services to complete the process of member enrollment.

9. Purpose of the Request for Proposal

a. Managed care was implemented in Nebraska to improve the health and wellness of Medicaid clients by increasing their access to comprehensive health services in a cost-effective manner. As behavioral health services are added to the physical health delivery system, additional goals for all members include decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates that integrated physical and behavioral health managed care will achieve the following outcomes:

i. Improved health outcomes
ii. Enhanced integration of services and quality of care
iii. Emphasis on person-centered care, including enhanced preventive and care management (CM) services
iv. Reduced rate of costly and avoidable care
v. Improved financially sustainable system

b. MLTC intends to award a minimum of two (2) and a maximum of three (3) MCO contracts through this procurement process which will provide integrated managed care health services statewide for all 93 counties in the State.

10. Included Populations

Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

a. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

b. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability.

c. Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population.

d. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP).

e. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

f. Medicaid beneficiaries who participate in a HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act.

g. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).

h. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined.

i. Members eligible during a period of presumptive eligibility.

11. Excluded Populations

Within the groups identified above, the following categories of beneficiaries are excluded from managed care:

a. Aliens who are eligible for Medicaid for an emergency condition only.

b. Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services.

c. Beneficiaries who have received a disenrollment or waiver of enrollment.

d. Participants in the Program for All-Inclusive Care for the Elderly.

e. Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

12. Changes to Population Groups and Services

MLTC may add, delete, or otherwise modify included and excluded population groups and services. If changed, the contract will be amended, and the MCO given as much advance notice as reasonably possible.

B. ELIGIBILITY AND ENROLLMENT

1. Eligibility

a. DHHS administers and manages eligibility for Medicaid and economic assistance programs through ACCESSNebraska. Individuals can apply for Medicaid benefits on the ACCESSNebraska website (ACCESSNebraska.ne.gov), over the telephone with dedicated Medicaid eligibility customer service staff, or by visiting designated local offices.

b. Regulations covering eligibility for Nebraska Medicaid are available in Title 477 of the Nebraska Administrative Code.

c. Renewals of Medicaid and CHIP eligibility are conducted annually.

2. Member Enrollment/Assignment

a. The MCO must comply with all enrollment and disenrollment procedures described in this section of the RFP.

b. The MCO and all its staff and subcontractors must have an understanding of the Medicaid population and the enrollment process. The MCO must work cooperatively with MLTC to resolve issues relating to enrollee participation and the enrollment process.

c. The State maintains responsibility for the enrollment of members into MCOs through a contractual arrangement with its enrollment broker. The State or its enrollment broker provides enrollees with access to a member guidebook, plan matrix, and provider directory to assist each enrollee in choosing a MCO plan and a PCP. The enrollment broker provides impartial choice counseling to assist each enrollee in choosing an MCO.

d. Enrollees are requested to enroll with a MCO plan and select a PCP within 15 calendar days of receipt of the MCO enrollment outreach letter, which is sent by either MLTC or its enrollment broker.

e. The enrollment broker is the only entity, other than MLTC, authorized to assist a Medicaid enrollee in the selection of a MCO. The enrollment broker is responsible for notifying all managed care enrollees and MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

f. Potential enrollees determined mandatory for managed care will be immediately enrolled in managed care after the required choice period, retroactive to the first day of the first month of the member's eligibility for Medicaid.

g. The MCO must have the technological capability and resources to interface with the State's and the enrollment broker's systems as necessary to support all aspects of the enrollment and disenrollment processes.

h. The MCO's eligibility system must show the member's effective date with the MCO as the first day of the month in which the member is determined Medicaid eligible. For example, if the State's eligibility file indicates the member was determined Medicaid eligible on 3/2/2015, and assigned to the MCO on 3/11/2015, the MCO's eligibility system must reflect an eligibility and enrollment date of 3/1/2015.

i. For current Heritage Health members at the time of the effective date of this contract, the annual enrollment choice period will be aligned with the contract start date. For example, if a member was determined Medicaid eligible retroactive to November 1, 2016, the MCO enrollment date will be the contractor start date.

j. MLTC and its enrollment broker shall make every effort to ensure that Medicaid eligible individuals who are excluded from managed care are not enrolled in a MCO. To ensure that such individuals are not assigned to a MCO, the MCO must work with MLTC or its enrollment broker to identify these individuals. The MCO must also notify MLTC if it learns that a member is no longer Medicaid eligible.

k. The State will automatically re-enroll a member who is disenrolled solely because he or she loses Medicaid eligibility, when a loss of eligibility does not exceed two months, into the same MCO (and assign the individual to the same PCP).

3. Auto-Assignment Algorithm

a. Prior to the contract start date, all current Heritage Health members and enrollees will be allowed an open enrollment period to select a MCO and choose a PCP. Current MCO members who do not select a MCO during that time frame will be assigned automatically to one as of the effective date of this contract.

b. Auto-assignment algorithms and decisions are at the sole discretion of MLTC and all MCOs must abide by the auto-assignment decisions.

c. The enrollment broker will auto-assign enrollees who do not select a specific MCO.

d. When an enrollee cannot be enrolled into his/her requested MCO because of a MLTC-imposed sanction or for another reason, the enrollee will be auto-assigned to another MCO.

e. In accordance with 42 Code of Federal Regulations (CFR) 438.50(f), the automatic assignment methodology will seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients. After consideration of provider-recipient relationships, the methodology will assign recipients equitably among MCOs, excluding those subject to an intermediate sanction. The automatic assignment methodology will not take into consideration the enrollee's previous MCO assignment.

f. The automatic assignment methodology is based on the following considerations:

i. If an enrollee has immediate family or household members enrolled in a MCO, the enrollee will be enrolled in that MCO.

ii. If the member's PCP is not currently in-network, the enrollment broker will use a round robin method to determine the MCO assignment that maximizes the preservation of existing provider relationships.

iii. If a MCO's membership is comprised of 40% or more of total statewide enrollment at the end of any quarter, that plan will be removed from the auto-assignment round robin process for the following quarter but members can continue to pro-actively select that plan.

iv. In addition, the MCO's quality measures may be factored into the algorithm for auto-assignment, at the discretion of MLTC.

v. Auto-assignment will attempt to balance enrollment among the MCOs, but is not guaranteed.

4. MCO Enrollment Procedures

a. Acceptance of All Eligible Individuals

i. The MCO must accept all eligible individuals who select it or are assigned to it. The MCO must not discriminate against MCO members on the basis of their health history, health status, need for health care services, or adverse change in health status; or on the basis of age, religious belief, gender, sexual orientation, ethnicity, or language needs.

ii. This applies to enrollment, re-enrollment, or disenrollment from the MCO. The MCO may be subject to monetary penalties and other sanctions if it is determined by MLTC that the MCO has requested disenrollment for any of these reasons.

iii. The MCO must accept enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set by MLTC.

b. Effective Date of Enrollment

i. The effective date of enrollment in the MCO is the date provided on the outbound ANSI ASC X12 834 electronic transaction initiated by MLTC or the enrollment broker. In general, a member's effective date of enrollment in a MCO is the first day of the month of the member's eligibility for Medicaid.

ii. Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in a MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the individual's enrollment.

iii. The MCO is not liable for the cost of any covered services provided to a Medicaid enrollee prior to the effective date of enrollment, but is responsible for the cost of covered services obtained on or after the effective date of enrollment.

c. Change in Status

i. The MCO must notify via ACCESSNebraska any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address, email address, and telephone number, in a manner and format required by MLTC.

ii. The MCO must initiate a request for disenrollment through the enrollment broker for other known changes in status, including but not limited to, death or, entry into involuntary custody or incarceration.

d. Newborn Enrollment

i. Once the State eligibility system is updated with a record of a live birth, the newborn will be immediately enrolled in either the mother's or an eligible sibling's MCO. The mother's MCO supersedes any sibling's, in the event that the mother and any sibling are enrolled in different MCOs.

ii. The MCO must contact members who are pregnant a minimum of 60 calendar days prior to the expected delivery date to encourage mothers to choose a PCP for their newborns. In the event that a pregnant member does not select a PCP, the MCO must give the member a minimum of 14 days after the birth to select a PCP prior to the MCO assigning one.

iii. A newborn may be inadvertently enrolled in a MCO different from its mother. When this situation is identified, MLTC will immediately:

a) Disenroll the newborn from the incorrect MCO.

b) Enroll the newborn in the same MCO as its mother with the same effective date.

c) Recoup any payments made to the incorrect MCO for the newborn.

d) Make payments to the correct MCO for the period of coverage.

iv. The MCO in which the newborn is correctly enrolled is responsible for the coverage of and payment for covered services provided to the newborn for the full period of eligibility. The MCO in which the newborn was incorrectly enrolled has no liability for the coverage of or payment for any services during the period in which the newborn was incorrectly assigned. MLTC is only liable for the capitation payment to the correct MCO.

v. The MCO is responsible for ensuring that hospital providers report births of members to the MCO within 24 hours of the birth. If the member makes a PCP selection during the hospital stay and one was not already identified, the MCO is responsible for ensuring the hospital provider reports this information to the MCO.

5. PCP Assignment

a. At initial enrollment, if an enrollee selects a MCO and a PCP, the assignment of the PCP will be included on the enrollment file sent to the MCO.

b. If no PCP selection is indicated on the enrollment file, the MCO must:

i. Contact the member within ten (10) business days of receiving the enrollment file to assist the member in selecting a PCP.

ii. Inform the member that each family member has the right to choose his/her own PCP, explaining the advantages of selecting the same PCP for all family members, as appropriate.

c. Members who do not choose a PCP within ten (10) days of enrollment with a MCO must be auto-assigned one by the MCO within one (1) month of the enrollment date, in compliance with 42 CFR 438.50(f).

d. The MCO is responsible for developing a PCP auto-assignment methodology in collaboration with the State to assign a member to a PCP when the member:

i. Does not make a PCP selection.

ii. Selects a PCP within the MCO's network that has reached his/her maximum physician/patient ratio or has a closed panel.

iii. Selects a PCP within the MCO's network that has restrictions or limitations (e.g., pediatric practice only).

e. If either of the two (2) situations set forth in provision d.i or d.ii immediately above occur, the MCO must reach out to the member and ask him/her to make an alternate PCP selection. If the MCO cannot reach the member after three (3) attempts or the member does not wish to choose a different PCP, only then may the MCO auto-assign the member to a PCP.

f. If appropriate, assignment must be made to a PCP with whom the member had a historical provider relationship. If there is no historical PCP relationship, the member must be assigned to a provider who is the PCP for an immediate family member in the MCO. If there is no family or historical relationship, members must be auto-assigned a PCP using an algorithm developed by the MCO based on the age and sex of the member and geographic proximity.

g. If a member is a dual eligible individual, the MCO must not require him/her to choose a new PCP through the MCO, and must not prevent the member from receiving primary care services from the member's existing Medicare PCP.

h. The MCO must report all PCP assignments to either MLTC or the enrollment broker at a frequency defined by MLTC. Currently, the system interface is completed on a monthly basis. Future system interfaces may be required to be completed on a daily basis.

i. The MCO must have written policies and procedures for PCP assignment. These policies and procedures must be approved in advance of their implementation by MLTC.

6. MCO Changes

a. Each member will be given 90 calendar days from the effective date of MCO enrollment (or the postmark date of the member's notification of enrollment with the MCO, whichever is later) in which he or she may change to another MCO for any reason.

b. After the initial 90 calendar day period, Medicaid members will be locked into their MCO selection until the next annual open enrollment period. The annual open enrollment period will be aligned with the contract start date.

7. Disenrollment

a. Disenrollment is any action taken by MLTC or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by MLTC or its designee that the member is no longer eligible for Medicaid or the HERITAGE HEALTH.

b. The enrollment broker is the single point of contact with the MCO member regarding notification of disenrollment.

c. A member may initiate a request for disenrollment from a MCO as follows:

i. For cause, at any time, under the following circumstances:

a) The MCO does not, because of moral or religious objections, cover the service the member seeks.

b) The member needs related services to be performed at the same time, and not all the related services are available with the MCO, and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.

c) The contract between the MCO and MLTC is terminated.

d) Lack of access to MCO benefits and services covered under the contract.

e) Other reasons, including but not limited to, poor quality of care, or lack of access to providers experienced in dealing with the member's health care needs.

ii. Without cause for the following reasons:

a) Once a year during the member's annual enrollment choice period.

b) Upon automatic re-enrollment under 42 CFR 438.56(g), if a temporary loss of Medicaid eligibility caused the member to miss the annual enrollment choice opportunity.

c) If MLTC imposes the intermediate sanction provisions specified in 42 CFR 438.702(a) (3) on the MCO.

iii. The member (or his or her representative) must submit a written request of disenrollment with cause to the enrollment broker for action by MLTC.

iv. If the member's request for disenrollment is denied, the member can appeal the decision through the State's fair hearing process.

8. MCO-Initiated Disenrollment

a. The MCO may not request disenrollment because of a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-existing medical condition; refusal of medical care or diagnostic testing; uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the MCO's ability to furnish services to the member or other MCO members; or, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise her/her right to change, for cause, the PCP that he/she chose or was assigned. (42 CFR 438.56(b)(2)).

b. The following are the only reasons for which the MCO may request disenrollment of a member:

i. The MCO has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the member, including circumstances in which the member misuses or loans the member's ID card to another person to obtain services. If this occurs, the MCO must report it to MLTC.

ii. The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members.

c. The MCO must not request disenrollment for reasons other than those stated in this RFP. In accordance with 42 CFR 438.56(b)(3), MLTC will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the MCO disenrollment requests submitted to the enrollment broker and the quarterly disenrollment reports submitted by the MCO to MLTC.

d. The MCO must take reasonable measures, as determined by the State, to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

e. When the MCO requests a member disenrollment, it must notify the member in writing of this request, the reason for the request, and the date of anticipated disenrollment.

f. The MCO must submit disenrollment requests to the enrollment broker that should include, at a minimum, the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment. The MCO must send notification of the disenrollment request to the member at the same time the request is made to the enrollment broker. The MCO must include documentation with the disenrollment request, as indicated in 482 NAC 000-03.

g. The MCO must not submit a disenrollment request for an effective date earlier than 45 calendar days after the event that prompted the disenrollment request. The MCO must ensure that disenrollment documents are maintained in an identifiable member record.

h. All requests will be reviewed on a case-by-case basis and decisions are at the sole discretion of MLTC or its designee. All decisions are final and not subject to the State's dispute resolution process.

i. The enrollment broker will provide written notice of disenrollment to the member and request the member to choose a new MCO. The notice will include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has the right to file an appeal directly to the State through the fair hearing process.

j. Until the member is disenrolled by the enrollment broker, the MCO is responsible for the provision of all benefits and services to the member.

9. Disenrollment Effective Date

a. The effective date of disenrollment will be no later than the first day of the second month following the calendar month in which the request for disenrollment is filed.

b. If MLTC fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment was filed, the disenrollment is considered approved.

c. The MCO, the enrollment broker, and MLTC must reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon written procedure.

10. MLTC-Initiated Disenrollment

a. MLTC or the enrollment broker will notify the MCO of the member's disenrollment for the following reasons:

i. Member is no longer Medicaid eligible.

ii. Member's death.

iii. Member's intentional submission of fraudulent information.

iv. Member becomes an inmate in a public institution.

v. Member moves out-of-state.

vi. A disenrollment decision is made by a hearing officer or court of law.

11. Enrollment and Disenrollment Updates

a. MLTC's enrollment broker will notify each MCO at specified times each month of the Medicaid eligible individuals that are enrolled, re-enrolled, or disenrolled from the MCO for the following month. The MCO will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

b. MLTC will use its best efforts to ensure that the MCO receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between MLTC and the MCO regarding enrollment, disenrollment, or termination, MLTC's decision is final.

12. Daily Updates

The enrollment broker will provide updates to the MCO daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction) of members newly enrolled with the MCO. The MCO must have written policies and procedures for receiving these updates, incorporating them into its management information system, and ensuring this information is available to its providers. Policies and procedures must be provided to MLTC for review and approval a minimum of 60 calendar days prior to the contract start date.

13. Weekly Reconciliation

a. The MCO is responsible for weekly reconciliation of the enrollment/disenrollment file received from the enrollment broker.

b. The MCO must provide written notification to the enrollment broker of any data inconsistencies within ten (10) calendar days of receipt of the file.

c. The MCO will receive a monthly electronic file (ASC X12N 820 transaction) from MLTC listing all members for whom the MCO received a capitation payment and the amount received. The MCO is responsible for reconciling this file against its internal records. It is the MCO's responsibility to notify MLTC of any discrepancies within three (3) months of file receipt. Lack of compliance with reconciliation requirements may result in the withholding of a portion of future monthly payments or other liquidated damages as defined in Section IV.V Contract Non-Compliance of the RFP.

C. BUSINESS REQUIREMENTS

1. Regulation and Guidance

a. The MCO must abide by all 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.

b. On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published a Proposed Rule (CMS-2390-P) regarding Medicaid managed care. MLTC anticipates that the finalizing of this proposed rule will affect the contracts awarded as a result of this RFP. The MCO must include in its proposal:

i. An analysis of the Proposed Rule that includes the MCO's interpretation of all provisions relevant to the contract requirements.

ii. A plan that details the processes and timeline the MCO will implement to ensure compliance with all applicable requirements in the proposed rule on the contract's start date. This plan must take into consideration requirements CMS is placing on states that require MCO cooperation/compliance.

The Proposed Rule can be reviewed at:
https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

2. Compliance with State and Federal Laws and Regulations

a. All contracts that result from this RFP must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. The MCO must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

b. The MCO must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers also do this when furnishing services to members.

3. Managed Care Organization Licensure

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 (DOI) at the time of proposal submittal, the MCO must attest that the appropriate licensure will be obtained prior to executing a contract with MLTC.

4. Accreditation

a. The MCO must attain health plan accreditation from the National Committee for Quality Assurance (NCQA). If the MCO is not currently accredited by NCQA, the MCO must attain NCQA accreditation within 18 months of the contract award.

b. The MCO's application for accreditation must be submitted as soon after the contract's start date as allowed by NCQA. The MCO must provide MLTC with a copy of all correspondence between the MCO and NCQA regarding the application process, the accreditation requirements, and the MCO's progress toward accreditation.

c. Achievement of provisional accreditation status will require a corrective action plan (CAP) within 30 calendar days of receipt of the final report from NCQA. Any failure to obtain full NCQA accreditation and to maintain the accreditation thereafter will be considered a breach of the contract and may result in contract termination at the sole discretion of the State.

5. Business Location

The MCO must establish and maintain a business office or work site within the State, staffed with the primary contract personnel and managers responsible for the services provided under the contract. The MCO is responsible for all costs related to securing and maintaining the facility for start-up and ongoing operations, including, but not limited to, hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. If any activities are approved by MLTC to be performed offsite, then the MCO must provide toll-free communications with MLTC staff to conduct those business operations. The MCO must provide meeting space to MLTC as requested when onsite at the MCO's location.

6. Cooperation with Other Entities and Programs

a. The MCO must develop processes and procedures and designate points of contact for collaboration with other entities and programs that serve members including but not limited to:

i. Division of Behavioral Health funded programs.

ii. Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State.

iii. Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities.

iv. The Nebraska Department of Education Early Development Network.

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

vi. The Office of Probation.

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

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

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

7. Service Orientation, Interoperability, and Data Exchange

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

8. Participation in the Nebraska Health Information Initiative

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

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

9. Participation in the MLTC Committees

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

10. Financial Viability/Solvency Requirements

a. Insolvency

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

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

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

iii. The cost of covered services provided to the member, for which MLTC or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

iv. Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the services directly.

b. Solvency

Each non-federally-qualified HMO must provide adequate assurances that Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent.

c. Continue Services During Insolvency

The MCO must continue to cover services for members for the duration of time for which payment has been made, as well as for inpatient admissions up until discharge.

11. Merger, Reorganization, and Change of Ownership

a. A proposed merger, reorganization, or change in ownership of the MCO requires prior approval of MLTC and will require a contract amendment. MLTC may terminate this contract pursuant to Section III Terms and Conditions. If the MCO does not obtain prior approval or MLTC determines that a merger, reorganization, or change in ownership is not in the best interest of the State, MLTC may offer open enrollment to the members assigned to the MCO. MLTC will not permit one organization to own or manage more than one contract within the same program.

b. The MCO must submit notification to MLTC of a merger, reorganization, or change of ownership a minimum of 180 days prior to its proposed effective date. The MCO must also submit a detailed merger, reorganization, or transition plan to MLTC for review a minimum of 90 calendar days prior to the effective date of the proposed change. The purpose of the plan's review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the MCO must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership.

12. Audit Requirements

a. The MCO must:

i. Maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, health records, and the administrative costs and expenses incurred pursuant to this contract as well as medical information relating to members as required for purposes of audit; or administrative, civil, or criminal investigations or prosecution per all retention requirements of this RFP. The MCO must ensure that this provision also applies to subcontractors, providers, or other entities providing goods or services under this contract. The MCO must provide MLTC with adequate assurances of its compliance with the immediately preceding sentence.

ii. Establish and maintain an internal audit function responsible for providing an independent review and evaluation of the MCO's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The MCO's internal audit function must perform audits to ensure the economical and efficient use of resources by all of its departments to accomplish the objectives and goals of each department. Further, the MCO's internal audit department is responsible for performing the claims payment accuracy tests described in Section IV.S Claims Management.

b. Audit Business Transaction

i. The MCO must obtain an audit of its business transactions from a licensed certified public accountant (CPA), including but not limited to, the financial transactions made under this contract.

ii. No later than December 1 of each year, the MCO must submit a copy of the fully executed engagement letter with the CPA to MLTC.

iii. No later than June 1 of each year, the MCO must submit a full and complete copy of the audit report to MLTC.

c. MLTC and CMS may inspect and audit any records of the MCO or its subcontractors. There is no restriction on the right of MLTC or the Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.

13. Access to Records

The MCO must allow Federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, the US Department of Health and Human Services (DHHS) awarding agencies, the Federal DHHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of the MCO that are pertinent to the contract, in order to make audits, examinations, excerpts, transcripts, and copies of such documents.

14. Compliance

The MCO is responsible for compliance with all contract requirements, regardless of whether the MCO enters into a subcontract to delegate performance of the contract requirements. The MCO must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 120 calendar days prior to their planned implementation. Prior to selecting a subcontractor, the MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated a minimum of 90 calendar days prior to the planned contract start date. MLTC reserves the right to participate in these evaluations, and the MCO must submit a copy of its findings to MLTC a minimum of 30 calendar days prior to the contract's start date. The MCO must monitor and formally review a subcontractor's performance on an ongoing basis.

15. Confidentiality

The MCO must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.

16. Protections Against Liability

Providers may not bill members any amount greater than would be owed if the MCO provided the services directly (i.e., no balance billing by providers is permitted).

17. Data Certification

Data submitted by the MCO to MLTC must be certified as required by 42 CFR 438.606:

a. The data that must be certified includes, but is not limited to, all documents specified by MLTC, enrollment information, encounter data, and other information contained in contracts and proposals. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the documents and data. The MCO must submit this certification concurrently with the certified data and documents.

b. Data and documents the MCO submits to MLTC must be certified by the MCO Chief Executive Officer, the MCO Chief Financial Officer, or an individual who has been delegated authority to sign for, and who reports directly to, the MCO Chief Executive Officer or Chief Financial Officer.

18. Moral or Religious Objections

a. A MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds.

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

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

D. STAFFING REQUIREMENTS

1. General Requirements

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

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

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

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

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

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

2. Key Staff Positions

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

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

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

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

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

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

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

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

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

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

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

Table 1. Key Staff

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

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

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

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

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

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

3. Additional Required Staff

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

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

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

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

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

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

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

h. Care management staff to assess, plan, facilitate, and advocate options and services to meet members' health and social needs. The staff must use communication and available resources to promote quality, cost-effective outcomes. The MCO is required to provide and maintain

appropriate levels of care management staff in the State to ensure adequate local geographical coverage for face-to-face contact with physicians and members as appropriate, and may include additional out-of-state staff providing telephone consultation and support.

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

j. All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and certain care management staff.

4. Care Management and Utilization Management Staff Requirements

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

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

5. Written Policies, Procedures, and Position Descriptions

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

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

6. Staff Training and Meeting Attendance

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

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

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

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

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

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

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

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

E. COVERED SERVICES AND BENEFITS

1. General Provisions

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

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

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

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

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

2. Amount, Duration and Scope

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

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

c. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. However, the MCO may place appropriate limits on a service on the basis of criteria such as medical necessity, or for

utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The MCO must provide its policies regarding this section to MLTC for approval a minimum of 45 calendar days prior to their implementation.

3. Behavioral Health Parity

The MCO must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes, but is not limited to:

a. Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more strictly than the medical management techniques that are applied to medical and surgical benefits.

b. Ensuring compliance with MHPAEA for any benefits offered by the MCO to members beyond those specified in the Medicaid State Plan.

c. Making the criteria for medical-necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracted provider, on request.

d. Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.

e. Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

4. Medically Necessary Services

a. The MCO must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the MCO is responsible for covering services related to the following:

i. The prevention, diagnosis, and treatment of health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

b. The MCO may not limit services beyond the limitations in the State's Medicaid program.

5. Second Opinions

When requested by the member, the MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member.

6. Value-Added Services

a. As permitted under 42 CFR 438.6(e), and to the extent consistent with provisions of State law, the MCO may, in its discretion, offer expanded services and benefits to enrollees in addition to those benefits and services specified in this section of the RFP.

b. These expanded services and benefits must, in the judgment of the MCO, be medically appropriate and cost-effective. The expanded services may include health care services that are currently non-covered services by the Medicaid State Plan or which are in excess of the amount, duration, and scope in the Medicaid State Plan.

c. These services/benefits must be specifically defined by the MCO with regard to amount, duration, and scope. MLTC will not provide any additional reimbursement to the MCO for these services or benefits.

d. The MCO must provide to MLTC a description of the expanded services or benefits to be offered by the MCO for approval 45 calendar days prior to implementation. Additions, deletions, or modifications to value-added services made during the contract period must be submitted to MLTC for approval a minimum of 45 calendar days prior to their implementation.

e. The following MLTC priorities may be addressed through value-added services:

i. Reduction in non-emergent use of the emergency department (ED) through increased access to after-hours care, urgent care, same-day appointments, data sharing with physicians and hospitals, member education, and/or other interventions identified by the MCO.

ii. Improved birth outcomes through prenatal, postnatal, and inter-pregnancy care, reduction in early elective deliveries and Cesarean sections, promotion of vaginal birth after Cesarean section, and other interventions identified by the proposer.

iii. Improved outcomes through coordination and integration of prevention-focused physical and behavioral health services delivered in community-based settings.

f. Value-added services are not Medicaid-funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. The MCO must send the member a notification letter if a value-added service is not approved.

g. Transportation to obtain these services or benefits is the responsibility of the member or the MCO, at the discretion of the MCO.

7. Telehealth and Telemonitoring Services

a. In-person contact between a health care provider and a patient is not required by Title XIX or XXI of the Social Security Act. The MCO must cover medically necessary telehealth services at a rate comparable to an in-person consultation. The MCO may also reimburse the originating site.

b. Health care providers that provide telehealth must follow all applicable State and Federal regulations governing their practice and the services they provide.

c. All telehealth communications must comply with all applicable Federal and State requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

d. The MCO shall, at a minimum, cover telemonitoring services when the following conditions have been met:

i. The member has been hospitalized two or more times in the last twelve (12) months for conditions related to the disease. This provision is not required for infant apnea monitoring.

ii. The member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data.

iii. The originating site has space for all program equipment and full transmission capability.

iv. The provider's record contains data that supports the medical necessity of the service, all transmissions, and subsequent review received from the member, and how the data transmitted from the member is used in the continuous development and implementation of the member's plan of care.

8. Core Benefits and Services

The following services represent a minimum benefit package that must be provided by the MCO to its members:

a. Physical Health Services

i. Inpatient hospital services, including transitional hospital services and transplant services.

ii. Outpatient hospital services.

iii. Ambulatory surgical center (ASC) services.

iv. Physician services, including services provided by nurse practitioners, certified nurse midwives, and physician assistants, and clinic-administered injections/medications, and anesthesia services including those provided by a certified registered nurse anesthetist.

v. Services provided in federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

vi. Services provided in Indian Health Service (IHS) facilities.

vii. Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis.

viii. Radiology services.

ix. Health Check (EPSDT) services.

x. Home health services.

xi. Private duty nursing services.

xii. Therapy services (physical therapy, occupational therapy, and speech pathology and audiology).

xiii. Durable medical equipment and medical supplies, including hearing aids, orthotics, prosthetics, and nutritional supplements.

xiv. Podiatry services.

xv. Chiropractic services.

xvi. Vision services.

xvii. Free standing birth center services.

xviii. Hospice services, except when provided in a nursing facility.

xix. Skilled/rehabilitative and transitional nursing facility services.

xx. Ambulance services.

xxi. Non-emergency ambulance transportation.

xxii. Transplant services.

xxiii. Pharmacy services.

b. Behavioral Health Services

<u>Services for individuals age 20 and under, unless otherwise indicated:</u>

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital (acute and sub-acute).

iii. Psychiatric residential treatment facility (age 19 and under).

iv. Outpatient assessment and treatment:

a) Partial hospitalization.

b) Day treatment.

c) Intensive outpatient.

d) Medication management.

e) Outpatient therapy (individual, family, or group).

f) Injectable psychotropic medications.

g) Substance use disorder treatment.

h) Psychological evaluation and testing.

i) Initial diagnostic interviews.

j) Sex offender risk assessment.

k) Community treatment aide (CTA) services.

l) Comprehensive child and adolescent assessment (CCAA).

m) CCAA addendum.

n) Hospital observation room services (up to 23 hours and 59 minutes in duration).

o) Parent child interaction therapy.

p) Child-parent psychotherapy.

q) Applied behavioral analysis.

r) Multi-systemic therapy.

s) Functional family therapy.

v. Rehabilitation services

a) Day treatment/intensive outpatient.

b) CTA services.

c) Professional resource family care.

d) Therapeutic group home.

Services for adults age 21 and over:

i. Crisis stabilization services (includes treatment crisis intervention).

ii. Inpatient psychiatric hospital services (acute and sub-acute).

iii. Outpatient assessment and treatment:

a) Partial hospitalization.

b) Social detoxification.

c) Day treatment.

d) Intensive outpatient.

e) Medication management.

f) Outpatient therapy (individual, family, or group).

g) Injectable psychotropic medications.

h) Substance use disorder treatment.

i) Psychological evaluation and testing.

j) Electroconvulsive therapy.

k) Initial diagnostic interviews.

l) Ambulatory detoxification.

m) In-home psychiatric nursing.

iv. Rehabilitation services

a) Dual-disorder residential.

b) Intermediate residential (SUD).

c) Short-term residential.

d) Halfway house.

e) Therapeutic community (SUD only).

f) Community support.

g) Psychiatric residential rehabilitation.

h) Secure residential rehabilitation.

i) Assertive community treatment (ACT) and Alternative (Alt) ACT.

j) Community support.

k) Day rehabilitation.

9. Laboratory and Radiology Services

a. The MCO must provide inpatient and outpatient diagnostic laboratory testing, therapeutic radiology, and radiological services ordered or performed by any network provider.

b. For excluded services, such as dental, the MCO is responsible for laboratory or radiology services that may be required to treat an emergency or provide surgical services.

c. The MCO must provide for clinical lab services and portable (mobile) x-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain PCP-ordered laboratory services and x- rays.

d. The MCO may require service authorization for diagnostic testing and radiological services ordered or performed by any provider for its members.

10. Eye Care and Vision Services

As set forth in the Medicaid State Plan and applicable regulations, the MCO must provide to all members any medically necessary eye care, vision examinations, prescriptive lenses, frames, and treatments. Eye care and vision services are to be performed by a licensed ophthalmologist or optometrist, conforming to accepted methods of screening, and diagnosis and treatment.

11. Pharmacy Services

a. Covered Services

i. The MCO must provide its members with access to outpatient pharmacy services as defined under Section 1927 of the Social Security Act, described in the Medicaid State Plan and further described in this section.

ii. The MCO must provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit and must follow the Nebraska Medicaid preferred drug list (PDL).

iii. The MCO must provide coverage for all drugs deemed medically necessary for members under the age of 21 years.

iv. The MCO may manage utilization of drugs through procedures that may include, but are not limited to, prior authorization and utilization and clinical edits.

b. Program Requirements

i. All policies and procedures related to the provision of the pharmacy benefit, including the formulary, UR policies, procedures to ensure compliance with the PDL, clinical and utilization edits, provider requirements, subcontracts, pricing, and reimbursement must be submitted to MLTC for written approval a minimum of 60 calendar days prior to the contract start date.

ii. The MCO must submit any proposed pharmacy program or coverage changes to MLTC for review and approval a minimum of 30 calendar days prior to proposed implementation of the change.

iii. The MCO must have procedures in place to provide a 72-hour supply of medication to a member in the event of an emergency situation on the weekends, holidays, or during off-hours.

iv. The MCO must maintain a website and post current and accurate information and documents regarding its pharmacy program. Such information must be current and searchable including, but not limited to the following:

a) The MCO formulary (list of covered medications) and the NE Medicaid PDL.

b) The MCO pharmacy prior authorization requirements.

c) The MCO maximum allowable cost (MAC) pricing.

d) Instructions on how and whom to contact for questions regarding filling a prescription.

e) A provider manual as a guideline for pharmacy claim submission. The manual must include, but is not limited to:

1) Payer sheet

2) Call center hours

3) Paper claim submission requirements

4) Compound prescriptions requirements

5) Prospective DUR response requirements

6) Toll-free call center numbers

v. The MCO formulary may only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO shall include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition for FDA-approved indications.

vi. The MCO must allow access to all new prescription drugs that are approved by the Food and Drug Administration, distributed by a labeler who participates in the Medicaid Drug Rebate Program, and are medically necessary either by addition of the drugs to the formulary or through prior authorization within ten calendar days from their availability in the marketplace.

vii. The MCO must at a minimum follow MLTC guidelines for off-label drug use.

viii. The MCO must support e-prescribing transactions, including, but not limited to member eligibility, formulary and benefit, and medication history. All transactions and data feeds to support e-prescribing must remain compliant with the National Council for Prescription Drug Programs (NCPDP) and the CMS-defined NCPDP SCRIPT standard version and supporting transactions. The MCO must remain compliant with the most current CMS-defined version of the NCPDP SCRIPT standard. All changes to support updates to the SCRIPT standard are the responsibility of the MCO and must be updated on a timeline to meet CMS-defined implementation dates at no cost to the Nebraska Medicaid program.

ix. The MCO may require prior authorization as a condition of coverage or payment for an outpatient prescription drug or device provided that:

a) The MCO provides a response to the prescriber and pharmacy by telephone, fax, or email indicating approval or denial of the request within one business day of the request; and

b) The MCO complies with the requirements for prior authorization for outpatient prescription drugs in accordance with Section 1927 of the Social Security Act.

x. The MCO must submit its policies and procedures on extemporaneously compounded drugs to MLTC for review and written approval prior to the start date of operations. Any subsequent changes to approved policies must be submitted to MLTC for review and written approval.

xi. The MLTC pharmacy benefit design currently uses the First Data Bank (FDB) drug reference file. MLTC may communicate coverage decisions using the FDB classification system. The MCO must be responsible to determine equivalent benefit designation if the FDB drug reference file is not used by the MCO.

c. Nebraska Medicaid Preferred Drug List

i. The MCO must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. Refer to the following link for additional information:
http://dhhs.ne.gov/medicaid/Pages/med_pharm.aspx

ii. The MLTC PDL vendor will provide to the MCO a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC.

iii. The MCO must update the pharmacy claim system within one (1) business day of file receipt of the PDL file.

iv. The MCO must, at the direction of MLTC, perform off-cycle PDL file updates within one (1) business day.

v. The MCO must implement Pharmacy and Therapeutics Committee-reviewed PDL changes posted to the MLTC PDL website on the first day after the 30 calendar day public notice posting of such changes.

vi. The MCO is not authorized to and must not negotiate rebates with manufacturers for pharmaceutical products listed on the PDL. MLTC or its designee will negotiate rebate agreements. Regardless if the MCO or its PBM has an existing rebate agreement with a manufacturer, all Nebraska Medicaid outpatient drug claims, including provider-administered drugs, must be rebateable exclusively to Nebraska Medicaid.

vii. The MCO must nominate a non-voting member to attend the Nebraska Pharmaceutical and Therapeutics Committee's biannual meetings during the term of this contract. Written final approval of nominees is made by MLTC.

d. Contractor Formulary

i. The MCO must cover medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act.

ii. The MCO must provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit.

iii. The MCO must submit the formulary for review and approval by MLTC a minimum of 90 calendar days prior to the contract start date.

iv. The MCO must submit all proposed formulary changes, excluding formulary expansion changes, to MLTC for review and written approval prior to the implementation of such changes.

v. The MCO must submit formulary prior authorization and step therapy policies and procedures, and any associated criteria, to MLTC for review and written approval a minimum of 60 calendar days prior to the contract start date. Clinical criteria for prior authorization of drugs require advance written approval of MLTC.

vi. The MCO must update the formulary files at a minimum on a weekly basis.

e. Over-the-Counter (OTC) Coverage

The MCO must, at a minimum, cover the OTC drugs listed in the Medicaid State Plan.

12. EPSDT Services

a. EPSDT is a comprehensive and preventive child health program for members under the age of 21.The EPSDT statute and Federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services not included in a state's Medicaid State Plan, if necessary, to correct or ameliorate a known medical condition (42 U.S.C. 1396d(r)(5) and the CMS Medicaid State Manual). The program consists of two (2) mutually supportive, operational components: (1) ensuring the availability and accessibility of required health care services; and (2) helping Medicaid members and their parents or guardians effectively use these services. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

The MCO must provide:

i. Effective outreach/education that informs parents/guardians of the benefits of having their children receive EPSDT screening, diagnosis, and treatment services.

ii. Education to parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children.

iii. Continuing and comprehensive health care beginning with the screening, and continuing through diagnosis and treatment for any conditions identified during screenings.

iv. Assistance to families in making medical appointments and obtaining needed transportation.

v. The monitoring of provided EPSDT services, to ensure that all services are delivered within established time frames.

b. The MCO must have written procedures for EPSDT services in compliance with 42 CFR Part 441 Subpart B, as well as be in compliance with the CMS State Medicaid Manual, Part 5 – EPSDT. These documents outline the requirements for EPSDT, including assurance that all EPSDT

eligible members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that tracking or follow-up occurs to ensure all necessary services are provided to all of the MCO's eligible Medicaid children and young adults.

c. The MCO is required to authorize and provide all medically necessary services (including behavioral health services), whether specified in the Medicaid State Plan or not, except those services that have been identified in this RFP as excluded or prohibited.

d. The MCO is required to ensure the provision of the medical, vision, and hearing screening components and immunizations as specified in the American Academy of Pediatrics periodicity schedule.

e. The MCO must facilitate access to medically necessary behavioral health services recommended during an EPSDT examination when requested by the member or his/her parent/guardian or when the MCO determines that it is necessary or appropriate.

f. The MCO must accurately report, via encounter data submissions, all EPSDT and well-child services, blood lead screening, access to preventive services, and any other services required for MLTC to comply with federally-mandated CMS 416 reporting requirements.

13. Immunizations

a. The MCO must provide to all members under 21 years of age all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices guidelines.

b. The MCO must ensure that all providers use vaccines available without charge under the Vaccine for Children program. This program provides vaccines to Medicaid children 18 years old and younger. Immunizations should be given in conjunction with EPSDT/well child visits or when other appropriate opportunities occur.

c. MCO providers must report required immunization data to the Nebraska State Immunization Information System, administered by DHHS/Division of Public Health. This requirement must be made a part of any contracts the MCO has with its providers.

14. Emergency Medical and Post-Stabilization Services

The MCO is responsible for coverage and payment of emergency services and post-stabilization care services regardless of whether the provider who/that furnishes the services has a contract with the MCO.

a. Emergency Services

i. The MCO must ensure that emergency services be rendered without the requirement of prior authorization of any kind. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.

ii. The MCO must not deny payment for treatment obtained when a representative of the MCO instructs the member to seek emergency services.

iii. The MCO must not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR 438.114(a).

iv. The MCO must not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

v. The MCO must not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

vi. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

vii. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO.

viii. The MCO must reimburse non-contracted providers for emergency services at no less than the Medicaid FFS rate in effect on the date of service.

b. Post-Stabilization Services

i. As specified in 42 CFR 438.114(e) and 42 CFR 422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:

a) Pre-approved by a network provider or other MCO representative.

b) Not pre-approved by a network provider or other MCO representative, but:

1) Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services, or

2) Administered to maintain, improve, or resolve the member's stabilized condition, and

i) The MCO did not respond to a request for pre-approval within one (1) hour;

ii) The MCO cannot be reached, or

iii) The MCO representative and the treating physician cannot reach agreement regarding the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

ii. The MCO's financial responsibility for post-stabilization care services that have not been pre-approved ends when:

a) A plan physician with privileges at the treating hospital assumes responsibility for the member's care.

b) A plan physician assumes responsibility for the member's care through transfer to another place of service.

c) A MCO representative and the treating physician reach an agreement concerning the member's care.

d) The member is discharged.

15. Emergency Ancillary Services Provided at a Hospital

Emergency ancillary services that are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine, and anesthesiology. Emergency ancillary services rendered by non-network providers in a hospital setting must be reimbursed at the published Medicaid fee schedule in effect on the date of service.

16. Family Planning Services

a. Family planning services are a mandatory Medicaid benefit. The MCO must not restrict the choice of provider from whom/which the member may receive family planning services and supplies. At a minimum, the MCO must provide coverage for the following family planning services:

i. Comprehensive medical history and physical exam in a frequency per year that meets or exceeds Medicaid limits. This visit includes anticipatory guidance and education related to members' reproductive health/needs.

ii. Contraceptive counseling to assist members in reaching an informed decision (including natural family planning, education follow-up visits, and referrals).

iii. Laboratory tests routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes and management of sexual health.

iv. Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs must also be covered.

i. Pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration.

v. Male and female sterilization procedures provided in accordance with 42 CFR Part 441, Subpart F.

vi. Treatment of major complications from certain family planning procedures such as: treatment of perforated uterus due to intrauterine device insertion; treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage; or, treatment of surgical or anesthesia-related complications during a sterilization procedure.

b. Services must include diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy, detection and treatment of sexually transmitted infections (STIs), and age-appropriate vaccination for the prevention of human papillomavirus infection and cervical cancer. Prior authorization must not be required for treatment of STIs.

c. MCO members have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR 431.51(b)(2).

d. The MCO must reimburse non-contracted family planning providers at no less than the FFS rate in effect on the date of service for properly billed claims.

e. The MCO may encourage members to receive family planning services through the MCO's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements will be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.

f. The MCO should encourage family planning providers to communicate with the member's PCP once any form of medical treatment in undertaken.

g. The MCO must limit coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem such as thyroid disease, brain tumor, or hormone dysfunction. The MCO must ensure coverage is not available if the sole purpose of the service is attempting to achieve a pregnancy, per 471 NAC 10-005.

17. Prenatal and Maternity Care Services

a. The MCO must cover routine prenatal care, delivery, six (6) weeks post-partum care, and routine urinalysis.

b. The MCO must cover nurse-midwife services that are medically necessary in accordance with their scopes of practice as defined by the applicable statutes and regulations.

c. Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both mother and newborn child.

18. Hysterectomies and Sterilizations

a. The MCO must cover the cost of medically necessary hysterectomies as provided in 42 CFR 441.255. Sterilizations must be conducted in accordance with 471 NAC 000-109, 10-005.07, 18-004.06 and Federal regulations at 42 CFR 441.250 – 441.259.

b. A hysterectomy or sterilization will not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing. It will also not be covered if there was more than one purpose for it, but the primary purpose was to render the individual permanently incapable of reproducing.

19. Limitations on Abortions

a. The MCO must ensure that abortion services are approved in writing by both the MCO Medical Director and the MLTC Medical Director before the service is rendered to ensure compliance with Federal and State regulations.

b. The MCO must only provide for abortion services in accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008, which stipulate that abortions are covered only in instances where pregnancy is the result of either:

i. An act of rape or incest; or

ii. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

c. For abortion services performed in accordance with this section, a physician must certify in his/her writing, that, on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider must attach the certification statement to the claim form that must be retained by the MCO. The certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering.

d. No other abortions, regardless of funding, can be provided as a benefit under this contract. The MCO must not make payment for any core benefit or service under the contract to a network or non-network provider if any abortion performed hereunder violates Federal regulations (e.g., the Hyde Amendment Codification Act).

20. Speech Pathology and Audiology

The MCO must cover, at a minimum, speech pathology and audiology services when the following criteria are met:

a. The services are ordered by a licensed physician.

b. The services are medically necessary.

c. The services or the condition of the member is/are so complex and sophisticated that only a licensed speech pathologist or audiologist could safely and effectively perform the service.

d.

e. The speech pathology or audiology service meets a minimum of one of the conditions listed at 471 NAC 23-003.01 or 23-003-02.

21. Transplants

The MCO must pay for all covered services associated with transplant care for a member. As required by 471 NAC 18-004.40, the MCO must cover transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental. If Medicare policy does not exist for a certain type of transplant, the MLTC Medical Director will determine whether the transplant is medically necessary and non-experimental. The MCO must cover at a minimum the following transplant types:

a. Heart and lung

b. Lung only

c. Heart only

d. Intestinal and/or multi-visceral

e. Kidney only

f. Pancreas only

g. Kidney and pancreas

h. Liver only

i. Bone marrow/stem cell

22. Medical Services for Special Populations

a. The special health care needs (SHCNs) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches.

b. The MCO must assess each member for SHCN within 90 calendar days of enrollment. The assessments must be completed by appropriate health care professionals. Assessments that determine a course of treatment or regular care monitoring, as appropriate, must result in a referral for care management.

c. The MCO must utilize Medicaid historical claims data (if available) to identify members who meet MCO guidelines for SHCN determination. These guidelines must be approved in writing by MLTC a minimum of 45 calendar days prior to their proposed implementation.

d. MCO PCPs must notify the MCO of those members who meet SHCN criteria as soon as possible after identification.

e. Members may self-identify to either the enrollment broker or the MCO that they have SHCNs. The enrollment broker will provide notification to the MCO of these members.

f. Individualized treatment plans resulting from SHCN assessments must be:

vi. Developed by the member's PCP, with member participation, and in consultation with any specialists caring for the member.

vii. Approved by the MCO in a timely manner, as defined and required by the MCO.

viii. Compliant with applicable QA and UM standards.

g. For members determined to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

23. Chiropractic Services

a. Chiropractic services coverage is limited to treatment of the spine by manual manipulation (i.e., by use of hands only) and certain spinal x-rays, per 471 NAC 5-002.

b. Unless provided as a value-added service, the MCO must not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including but not limited to laboratory tests, orthopedic devices, physiotherapy, nutritional supplements, EKGs, and acupuncture, as defined in 471 NAC 5-003.

24. Dialysis Services

The MCO must, per NAC 471 18-004, follow Medicare program guidelines for coverage of dialysis.

25. Durable Medical Equipment

a. The MCO must provide coverage and be financially responsible for medically necessary durable medical equipment (DME), prosthetics, orthotics, medical supplies, and assistive devices including, but not limited to, hearing aids.

b. The MCO must, at minimum, provide coverage for DME-related covered services as listed in Chapters 7 and 8 of Title 471 of the Nebraska Administrative Code.

26. Home Health Services

The MCO must cover the following home health agency services:

a. Skilled nursing services provided by a registered professional nurse or a licensed practical nurse.

b. Home health aide services.

c. Physical therapy provided by a licensed physical therapist.

d. Speech therapy provided by a licensed speech pathologist.

e. Occupational therapy provided by a licensed/certified occupational therapist.

27. Hospice Services

a. The MCO must provide a comprehensive package of hospice services to members, including nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services, and pastoral care services.

b. These services must be offered based upon individually assessed needs and choices of terminally ill members and their families for palliative care and support.

28. Medical Transportation Services

a. The MCO must provide emergency and non-emergency medical transportation by ambulance for its members.

b. The MCO may establish its own policy for medical transportation services as long as the MCO ensures members' access to care and the MCO's policy is in compliance with current Nebraska Medicaid guidelines for emergency and non-emergency medical transportation.

29. Excluded Services

Excluded services are those services that members may obtain under the Medicaid State Plan, and for which the MCO is not financially responsible. However, the MCO is responsible for informing members about how to access excluded services, providing all required referrals, and assisting in the scheduling of these services. These services will be paid for by MLTC on a FFS basis. Services include:

a. Dental services.

b. Intermediate care facility services for individuals with developmental disabilities.

c. Any institutional LTC/NF services at a custodial level of care.

d. School-based services.

e. All HCBS waiver services.

f. Targeted Case Management services.

g. Medicaid State Plan Personal Assistance Services.

30. Prohibited Services

a. Prohibited services are those required to treat complications or conditions resulting from non-covered services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the MLTC Director.

b. The MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) described in Section 1903(i) of the Social Security Act.

F. MEMBER SERVICES AND EDUCATION

1. Member Rights and Protections

a. Member Rights

i. The MCO must have written policies regarding members' rights that are specified in this section and in compliance with 482 NAC 7-001. At a minimum, each MCO member is guaranteed the right to:

a) Be treated with respect and consideration of his/her dignity and privacy.

b) Receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information.

c) Participate in decisions regarding his/her health care, including the right to refuse treatment. Refusal of treatment is not a reason for which the MCO can request disenrollment of the member from the MCO.

d) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

e) Request and receive a copy of his/her medical records, and request that they be amended or corrected as specified in 42 CFR 438.100.

f) Obtain available and accessible health care services covered under the contract.

g) Request disenrollment per 42 CFR 438.56.

ii. Each member is free to exercise his/her rights and entitled to a guarantee that the exercise of those rights will not adversely affect the member's treatment by the MCO, its providers, or MLTC.

b. Indian Health Protections

Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, the MCO must:

i. Permit any American Indian who is enrolled in a MCO and eligible to receive services from a participating Indian tribe, tribal organization, or urban Indian organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his/her PCP, as long as that provider has the capacity to provide the service.

ii. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian members who are eligible to receive services from such providers.

iii. In compliance with Section 5006(a) of the American Recovery and Reinvestment Act, (a) exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral, and (b) exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral.

iv. Follow required Indian health protections included in Section IV.Q Provider Reimbursement.

c. Notice to Members of Provider Termination

i. The MCO must make a good faith effort to provide affected members with written notice of a provider's termination from the MCO's network. This includes members who receive their primary care from, or were seen on a regular basis by, the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within 15 calendar days of the receipt of the termination notice from the provider.

ii. The MCO must provide notice to a member who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice must be provided within ten (10) calendar days from the date the MCO becomes aware of the change, if the notice is provided in advance.

iii. Failure to provide notice prior to the termination date is allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when the provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under any of these circumstances, notice must be issued immediately upon the MCO becoming aware of the circumstances.

2. Member Services Call Center

a. The MCO must:

i. Operate a member call center with a toll-free telephone line to respond to members', their families', and their providers' questions, concerns, inquires, and complaints.

ii. Develop member call center line policies and procedures that address staffing; training; hours of operations; access and response standards; transfers/referrals, including case management referrals from any source; monitoring of calls via recording or other means; and compliance with standards in this RFP.

iii. Ensure the call center staff can handle calls from members with limited English proficiency and members with disabilities, including but not limited to members with hearing or speech disabilities.

iv. Ensure the call center is staffed adequately to respond to members' questions, at a minimum from 8:00 am to 5:00 pm, central time, Monday through Friday.

v. Ensure the member call center provides an option to speak with qualified nurses at any time 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 from a care manager.

vi. Ensure that, during normal business hours, call transfers to case managers be made as warm transfers, i.e. when transferring a call, the call center staff provides the person picking up the call with a brief summary of the member's concern and introduces the member.

If call transfer is not possible, the MCO must ensure that a care manager is notified and returns the member's call within 30 minutes and that the care manager has access to the necessary information to resolve the member's issue. The MCO must implement protocols, approved in advance by MLTC, that describe how member calls to the nurse triage/nurse advice line will be handled.

vii. Ensure the member call center is adequately staffed with individuals trained to accurately respond to member questions regarding managed care, including but not limited to, covered services, the Medicaid program, EPSDT, and the MCO's provider network.

viii. Measure and monitor the accuracy of responses and telephone etiquette and take corrective action as necessary to ensure that members are being given correct information in a helpful and polite manner.

b. The MCO must install, operate, and monitor an automated call distribution system for business and non-business hours, including weekends and holidays. This automated system must:

i. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner.

ii. Transfer calls to other telephone lines, as necessary.

iii. Provide detailed reports in a format approved by MLTC, including the quantity, length, and types of calls received; the number of calls transferred or referred; abandonment rate; wait time; busy signal rate; response time; and call volume.

iv. Provide a message that notifies callers that calls may be monitored for QI purposes.

v.

vi. Provide callers with instructions about what to do in case of an emergency.

vii. Include a voice mailbox with adequate capacity.

viii. Measure the number of calls in the queue.

ix. Measure the length of time callers are on hold.

x. Measure the total number of calls and average calls handled per day, week, and month.

xi.

xii. Measure the average hours of use per day.

xiii. Assess the busiest times and days by number of calls.

xiv. Record calls to assess whether member questions are answered accurately and politely.

xv. Provide a backup telephone system that would operate in the event of line trouble, emergency situations including natural disasters, or other problems, so that access to the call center is not disrupted.

xvi. Provide interactive voice response (IVR) options that are user-friendly for members.

c. The MCO must meet the following call center performance standards:

i. Answer 90% of calls within 30 seconds or direct the call to an automatic call pickup system with IVR options.

ii. Ensure that no more than 1% of incoming calls receive a busy signal.

iii. Maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this RFP includes 1) the amount of time a caller waits for a member services representative to assist them after the caller has navigated the IVR system and requested a live person and 2) the amount of time a customer service representative places a caller on hold.

iv. Maintain an abandonment rate of calls of not more than 5%.

v. Return all voice mails no later than the next business day.

d. The MCO must conduct ongoing quality assurance to ensure call center performance standards are met.

e. If MLTC determines that it is necessary to conduct onsite monitoring of the MCO's member call center functions, the MCO is responsible for all reasonable costs incurred by MLTC or its authorized agent(s) related to such monitoring.

3. Oral Interpretation and Written Translation Services

a. In accordance with 42 CFR 438.10(b)(1), MLTC will provide to the MCOs, and on its website, the prevalent non-English languages spoken by members in the State.

b. The MCO must make real-time and culturally and linguistically appropriate oral interpretation services available free of charge to each Medicaid enrollee and member. This applies to all non-English languages, not just those that Nebraska specifically requires. The member must not be charged for interpretation services. The MCO must notify its members that oral interpretation is available for any language, written information is available in Spanish, and how they can access these services. Materials that provide this information must be written in English and Spanish.

c. The MCO must ensure that translation services are provided for all written marketing and member materials in any language that is spoken as a primary language for 4% or more members, or potential members, of the MCO. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials must be translated and made available. No charge can be assessed for these materials to ensure that all members and potential members understand how to access the MCO and use services appropriately as specified in 42 CFR 438.10(c)(4) and (5).

4. Requirements for Member Materials

a. The MCO must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).

b. The MCO must write all member materials in a style and reading level that will accommodate the reading skill of MCO members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.

c. MLTC reserves the right to require the MCO to submit evidence that written member materials were tested against the 6.9 grade reading-level standard.

d. The MCO must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the MCO's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website.

e. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual,

speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.

f. All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.

g. The MCO must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The MCO must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.

h. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC.

i. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans, if applicable.

j. The MCO's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.

k. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.

l. All written materials related to MCO enrollment and PCP selection must advise members to verify with their usual providers that they are participating providers in the selected MCO and are available to see the member.

m. Marketing materials must be made available by the MCO across the State. Materials may be customized for particular locations or populations within the State.

n. All marketing activities must provide for equitable distribution of materials without bias toward or against any group.

o. Marketing materials must accurately reflect information that is applicable to an average member of the MCO.

p. In all member materials, the MCO must include the date of issue or revision.

q. Copies of all member mailings/materials (print and multimedia) must be provided contemporaneously to MLTC.

5. Member Handbook

a. The MCO must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10(f)(6).

b. The draft member handbook must be submitted to MLTC for review and approval a minimum of 120 calendar days prior to the contract's start date.

c. The MCO must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it.

d. At a minimum, the MCO must review and update the member handbook annually. The MCO must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the MCO wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation.

e. The MCO's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the MCO

must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.

f. At a minimum, the member handbook must include:

i. A table of contents.

ii. A general description of basic features of how MCOs operate and information about the MCO in particular.

iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.

iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.

v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP.

vi. Appropriate and inappropriate behavior when seeing a MCO provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.

vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.

viii. A description of the PCP selection process and the PCP's role as coordinator of services.

ix. The member's right to select a different MCO or change providers within the MCO.

x. Any restrictions on the member's freedom of choice of MCO providers.

xi. A description of the purpose of the Medicaid and MCO ID cards, why both are necessary, and how to use them.

xii. The amount, duration and scope of benefits available to the member under the contract between the MCO and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.

xiii. Procedures for obtaining benefits, including authorization requirements.

xiv. The extent to which, and how, members may obtain benefits, including family planning services, from out-of-network providers.

xv. Information about health education and promotion programs, including chronic care management.

xvi. Appropriate utilization of services including not using the ED for non-emergent conditions.

xvii. How to make, change, and cancel medical appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".

xviii. Information about a member's right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it.

xix. The extent to which, and how, after-hours and emergency coverage are provided, including:

a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c).

b) That prior authorization is not required for emergency services.

c) The process and procedures for obtaining emergency services, including use of the 911-telephone system.

d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

xx. The policy about referrals for specialty care and for other benefits not furnished by the member's PCP.

xxi. How to obtain emergency and non-emergency medical transportation.

xxii. Information about the EPSDT program and the importance of children obtaining these services.

xxiii. Information about notifying the MCO if a female member becomes pregnant or gives birth, the importance of early and regular prenatal care, and obtaining prenatal and post-partum care.

xxiv. Information about member copayments. The charging of a copayment is at the discretion of the MCO. If the MCO chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR 447.50 through 447.57, and cannot exceed the amounts specified at 471 NAC 3-008.

xxv. The importance of notifying the MCO immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.

xxvi. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the MCO's contract with MLTC, either because the service is carved out or the MCO will not provide the service because of a moral or religious objection.

xxvii. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.

xxviii. Member grievance, appeal, and state fair hearing procedures and timeframes, as described in 42 CFR 438.400-424 and this RFP, as follows:

a) For grievances and appeals:

1) Definitions of a grievance and an appeal.

2) The right to file a grievance or appeal.

3) The requirements and timeframes for filing a grievance or appeal.

4) The availability of assistance in the filing process.

5) The toll-free number(s) the member can use to file a grievance or an appeal by telephone.

6) The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the

cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

b) For state fair hearing:

1) Definition of a state fair hearing.

2) The right to request a hearing.

3) The requirements and timeframes for requesting a hearing.

4) The availability of assistance to request a fair hearing.

5) The rules on representation at a hearing.

6) The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

xxix. As set forth in 42 CFR 438.6(i)(1) and in this section, a description of advance directives that includes:

a) The State's and MCO's policies about advance directives.

b) Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

xxx. Information about how members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements.

xxxi. How a member may report suspected provider fraud and abuse, including but not limited to, the MCO's and MLTC's toll-free telephone number and website links created for this purpose.

xxxii. Any additional information that is available upon request, including but not limited to:

a) The structure and operation of the MCO.

b) The MCO's physician incentive plan (42 CFR 438.6(h)).

c) The MCO's service utilization policies.

d) How to report alleged marketing violations to MLTC.

e) Reports of transactions between the MCO and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.

xxxiii. A minimum of once a year, the MCO must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

6. Other Member Notifications

The MCO must also provide the following information to each member:

a. A minimum of annually, the MCO must provide an explanation of a member's disenrollment rights to each member. The notice must be sent no less than 60 calendar days before the start of each enrollment period.

b. A minimum of annually, the MCO will inform all members of their right to request the following information in compliance with 42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2).

i. An updated member handbook, at no cost to the member.

ii. An updated provider directory, at no cost to the member.

7. Member Newsletter

a. The MCO must develop and distribute, a minimum of twice a year, a member newsletter. This publication must be available on the member portal and mailed to members on request. Topics covered in the newsletter must be timely and relevant to the member population. Suggested topics to discuss include but are not limited to:

i. Educational information on chronic illnesses and ways to self-manage care.

ii. Behavioral health information.

iii. Reminders of flu shots and other prevention measures at appropriate times.

iv. Medicare Part D issues.

v. Cultural competency issues.

vi. Tobacco cessation information and programs.

vii. HIV/AIDS testing for pregnant women.

viii. Other topics as requested by MLTC.

b. The MCO must submit a draft of the member newsletter to MLTC a minimum of 45 calendar days prior to its intended publication for review and approval.

8. Provider Directory for Members

a. The MCO must develop and maintain a provider directory for its members in three (3) formats:

i. A hard copy directory, when requested, for members, potential members, and the enrollment broker.

ii. A web-based, searchable, online directory for members, potential members, and the general public.

iii. An electronic file of the directory to be submitted and updated weekly to MLTC or its designee, and the enrollment broker.

b. The MCO must submit templates of its provider directory to MLTC a minimum of 45 calendar days prior to the contract start date for MLTC's review and approval.

c. The hard copy directory for members must be updated a minimum of monthly. The web-based version must be updated in real time, and no less often than three (3) business days after notification of any change. Daily updates are preferred, if possible.

d. In accordance with 42 CFR 438.10(f)(6), the provider directory must include, but not be limited to:

i. Names, locations, telephone numbers, specialties, and non-English languages spoken of all current contracted providers (including urgent care clinics, FQHCs, RHCs, labs, radiology providers, behavioral health providers, hospitals, and pharmacies) in the MCO's network. Those PCPs, specialists, and other providers who/that are not accepting new patients must be identified.

ii. Hours of operation, including identification of providers with non-traditional hours (before 8 am, after 5 pm, or any weekend hours).

e. To assist Medicaid enrollees in identifying participating providers for each MCO, the enrollment broker will use the MCO's file. This file will be available on the MCO's website, and should be provided to the enrollment broker in a machine readable file and format. As necessary, the enrollment broker will maintain hard copies of the MCO's directory to share with Medicaid enrollees on request.

9. Member ID Cards

MCO members will be issued a minimum of two separate member ID cards related to their Medicaid eligibility and their enrollment in the Nebraska Medicaid managed care delivery system. MLTC issues an ID card to all Medicaid eligible individuals, including MCO members. This card is not proof of eligibility, but can be used by providers to access the State's electronic eligibility verification systems. These systems contain the most current information available on members, including MCO enrollment. No MCO-specific information is printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO benefits and services.

a. The MCO must issue an ID card to each of its members. At a minimum, the card must include:

i. The member's name.

ii. The member's Medicaid ID number.

iii. The enrollment broker's toll-free telephone number.

iv. The MCO's name and address.

v. Instructions on what the member should do in the event of an emergency.

vi. The member's PCP's name and telephone numbers (including the after-hours number, if it is different).

vii. The MCO's toll-free number(s) for Member Services, filing a grievance, and reporting suspected fraud.

c. The MCO may provide the MCO member ID card in a separate mailing from the welcome packet. However, the ID card must be sent no later than ten (10) business days from the date of receipt of the file from MLTC or the enrollment broker that identifies the new member. As part of the welcome packet information, the MCO must explain the purpose of the card and how to use it in tandem with the MLTC-issued card.

d. The card may be issued without the PCP information if no PCP selection has been made as of the date of the card's mailing. Once PCP selection has been made by the member or through auto assignment, the MCO must reissue the card within ten (10) business days of the selection or auto-assignment. As part of the mailing of the reissued card, the MCO must explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

e. The MCO must reissue the MCO ID card to a member within ten calendar days of notice that a member has lost his/her card, had a name or PCP change, or for any other reason that requires a change to the information on the current ID card.

f. If the MCO has knowledge of any MCO member permitting the use of his/her ID card by any other person, the MCO must immediately report this information to the Special Investigation Unit in the Department of Health and Human Services Division of Public Health at (402) 471-9407 (Lincoln and Greater Nebraska) or (402) 595-3789 (Omaha).

g. The MCO must ensure that its subcontractors can identify members in a manner that will not result in discrimination against the members, in order to provide or coordinate the provision of all benefits and services, expanded services, and/or out-of-network services.

h. Pharmacy-Related ID Card Requirements

The MCO must provide, on the member's ID card, prescription billing information that:

vi. Complies with the standards set forth in the National Council for Prescription Drug Programs' Health Care Identification Card Pharmacy and/or Combination ID Card Implementation Guide at the time of issuance of the card.

vii. Includes, at a minimum, the following data elements:

a) The name or identifying trademark of the MCO and the prescription benefit manager.

b) All electronic transaction routing information and any other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.

10. Member Website

a. The MCO must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the MCO and receive responses).

b. The MCO website must include general and up-to-date information about the Nebraska Medicaid program and the MCO. All material to be included on the website must be submitted and approved by MLTC in advance of its intended posting. MLTC will review and approve or request changes as quickly as practical but within 30 calendar days of receipt.

c. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website.

d. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.

e. The MCO website must follow all written marketing guidelines included in Section IV G Member marketing..

f. Us of proprietary items that would require use of a specific browser or other interface is not allowed.

g. The MCO must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:

i. The most recent version of the member handbook.

ii. Telephone contact information for the MCO, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number.

iii. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the MCO network.

iv. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment.

v. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility.

vi. Information about how to file grievances and appeals.

11. Medical Records

a. A member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers, as well as but not limited to, those

kept in placement settings such as nursing facilities, assisted living facilities, and other home and community based providers.

b. Each member is entitled to a copy of his or her medical record at no cost.

c. The MCO must have written policies and procedures to maintain the confidentiality of all medical records in compliance with applicable law.

d. he MCO is responsible for ensuring that a medical record (hard copy or electronic) is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

e. The MCO must ensure the medical record includes, at a minimum, the following:

i. Member-identifying information, including name, member ID number, date of birth, gender, and legal guardianship (if applicable).

ii. Primary language spoken by the member and any translation needs.

iii. Services provided through the MCO, date of service, service site, and name of service provider.

iv. Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO.

v. Referrals including follow-up and outcome of referrals.

vi. Documentation of emergency or after-hours encounters and follow-up.

vii. Signed and dated consent forms (as applicable).

viii. Documentation of immunization status.

ix. Documentation of advance directives, as appropriate.

x. Documentation of each visit must include:

a) Date and begin and end times of service.

b) Chief complaint or purpose of the visit.

c) Diagnoses or medical impression.

d) Objective findings.

e) Patient assessment findings.

f) Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG).

g) Medications prescribed.

h) Health education provided.

xi. Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider. Initials of providers must be identified with correlating signatures.

xii. Documentation of EPSDT requirements including but not limited to:

a) Comprehensive health history.

b) Developmental history.

c) Unclothed physical exam.

d) Vision, hearing and dental screening.

e) Immunizations.

f) Lab testing including mandatory lead screening.

g) Health education and anticipatory guidance.

f. The MCO must have written policies and procedures for the maintenance of medical records to ensure that records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and facilitates an adequate system for follow-up treatment.

g. The MCO must have written standards for documentation on medical records for legibility, accuracy and plan of care that comply with applicable law.

h. When a member changes PCPs, his/her medical records or copies of medical records must be forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

i. MLTC is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. The MCO may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the Nebraska Medicaid program.

j. MLTC must be afforded access to all members' medical records, whether electronic or paper, within 20 business days of receipt of the request or more quickly if necessary in MLTC's sole determination.

k. Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in State statute, and substance use disorder information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

12. Advance Directives

a. The MCO must maintain written policies and procedures for advance directives, as described in 42 CFR 489.100.

b. The MCO must provide written information to all adult members with respect to:

vi. Their rights under applicable law.

vii. The MCO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

c. The MCO is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive.

d. The MCO must inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with MLTC or the DHHS Division of Public Health.

e. Any written information on advance directives must reflect changes in State law as soon as possible, but no later than 90 calendar days after the effective date of a change.

13. Communication with New Members

a. MLTC's enrollment broker is required to send to the MCO a daily electronic transmission file that contains the names, addresses, and telephone numbers of all members newly assigned to the MCO, with an indicator for members who were auto-assigned. The MCO must use this file to identify new members, initiate communication with new members via welcome packet mailings and calls, and assign members to a PCP, if the member has not already chosen one.

b. Welcome Packets

i. The MCO must send a welcome packet to new members within ten business days of receiving the new member file.

ii. The MCO must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two or more new members, the MCO is only required to send one welcome packet.

iii. All contents of the welcome packet are considered member materials and, as such, must be submitted for review and approval by MLTC a minimum of 45 calendar days prior to the contract's start date. The materials must comply with the requirements of this RFP and 42 CFR 438.10 (f)(6). The welcome packet must include, at a minimum:

a) A welcome letter with MCO contact information. If the MCO ID card is mailed separately, the welcome letter must also state that the member will receive his/her member ID card separately.

b) Information on how to request a member handbook.

c) The MCO member ID card (if not mailed separately).

d) Notice that the provider directory and Member Handbook are available on the member portal and that the member may request a hardcopy if he/she wants one. Directions for how to obtain hardcopies must be included in this notice.

e) Other information that the MCO wishes to include, such as an EPSDT program periodicity schedule, prenatal care materials, guidance regarding emergency services, availability of community services/resources, and any other materials that might be appropriate for the member.

c. Welcome Calls

i. The MCO must make welcome calls to new members within 15 business days of the date the MCO sends the welcome packet.

ii. A minimum of 45 calendar days prior to the contract's start date, the MCO must develop and submit to MLTC for approval a script to be used during the welcome call to discuss the following information with the member:

a) A brief explanation of the program.

b) A discussion of member confidentiality requirements.

c) The availability of oral interpretation and written translation services and how to obtain them free of charge.

d) The concept of patient-centeredness, including the importance of the member making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition. If the member did not already select his/her PCP, the member should be advised that s/he may select a PCP and the MCO must assist with this process, if needed.

e) A determination of whether the member is pregnant, has a chronic condition, faces barriers to accessing care (e.g., transportation needs, mobility limitations)

or any special health care needs. Assistance in making an appointment with the PCP must be offered to all members with any of these issues.

f) Assistance with any needed referrals, including but not limited to, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program.

iii. The MCO must make three (3) attempts to contact the member. If the MCO discovers that the member has lost or has never received the welcome packet, the MCO must resend it.

iv. The MCO must report to MLTC, on a monthly basis, the name, telephone number(s), and Medicaid Recipient ID Number of each member it was unable to contact after three (3) attempts.

v. The MCO may propose to MLTC an alternate method and plan for welcoming members per this section, if anticipated to be more effective. MLTC in its sole discretion may approve this alternate method.

14. Member Education

a. In all its written and verbal communications with its members, the MCO must provide ongoing education about how the member can improve his/her health and wellness. This should include, but not be limited to, the member handbook, the new member welcome packet, the member newsletter, other member mailings, and communication with member services representatives, case managers, and other MCO staff.

b. The MCO is responsible for educating members on the appropriate utilization of ER services, including behavioral health emergencies.

c. A minimum of 45 calendar days prior to the contract start date, the MCO must submit to MLTC for review and approval its proposed member education plan. This plan must include, but not be limited to:

i. The MCO's plans for new member outreach, including welcome packets and welcome calls, as well as ongoing member education.

ii. How the MCO plans to reach out to members in need of care management services.

iii. The MCO's plan to incorporate patient engagement tools such as smartphone-based support programs, mobile applications or text messaging innovations. A smartphone-based support program could include the following features:

a) Mobile applications and/or mobile-friendly content that is accessible across a broad range of electronic devices.

b) Consumer-friendly and engaging content that helps keep patients on-track with key health appointments and screenings.

c) Tools to help stratify users by risk profile and direct the higher risk users to State-based or MCO-based resources.

d) Outreach support to educate patients about the mobile tools.

e) Reporting and analytics to help the State measure the effectiveness of the electronically-based support program.

iv. How the MCO plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the State. This may include, but is not limited to, a description of the provisions for non-English speaking members, interpreter services, and alternate communication mechanisms (such as sign language, Braille, or audio tapes).

v. A list of all subcontractors engaged in marketing or member education activities for the MCO.

d. The MCO may not conduct member education or distribute member education materials in provider offices.

G. MEMBER MARKETING

1. General Guidelines for Marketing

a. Marketing, for the purposes of this RFP, is defined in 42 CFR 438.104(a) as any communication from a MCO to a Medicaid enrollee, who is not enrolled in that MCO, that can reasonably be interpreted to try to influence the Medicaid enrollee to 1) enroll in that particular MCO, or 2) either not enroll in, or dis-enroll from, another MCO.

b. Marketing is different than member education. Member education is defined as communication with a MCO member for the purpose of retaining the member as a member and improving his/her health status.

c. Marketing materials include both verbal presentation and written materials, as well as all types of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts, and electronic messages designed to increase awareness and interest in the MCO. This includes any information that references the MCO, is intended for general distribution, and is produced in a variety of print, broadcast, or direct marketing media.

d. All marketing activities must be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of members, Medicaid enrollees, or the general community.

e. All marketing materials and activities must comply with the requirements in 42 CFR 438.10 and the MLTC requirements set forth in this RFP.

f. Under the Nebraska Medicaid managed care program, all direct marketing to Medicaid enrollees or potentially eligible individuals will be performed by MLTC or its designee in accordance with 42 U.S.C. 1396u-2(d)(2)(A) and 42 CFR 438.104.

g. The MCO is responsible for the creation, production, and distribution of its own marketing and member materials. MLTC and its enrollment broker will only be responsible for distributing general material developed and produced by the MCO for inclusion in the enrollment package distributed to Medicaid enrollees. MLTC will determine which materials will be included in the enrollment broker generated packet and which materials will be distributed by the MCO.

h. Activities involving distribution and completion of a MCO enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of MLTC's enrollment broker.

i. The MCO must provide assurances to MLTC that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud members/enrollees or MLTC as specified in 42 U.S.C 1396u-2(d)(2) and 432 CFR 438.104. Marketing materials must not contain any assertion or statement (whether written or verbal) that:

i. The member must enroll in the MCO in order to obtain or not to lose benefits.

ii. That the MCO is endorsed by CMS, the Federal or State government, MLTC, or any similar entity.

j. If a person who provides a testimonial or endorsement for the MCO has a financial interest in the company, this fact must be disclosed in the member/marketing materials.

k. The MCO shall comply with the Office of Minority Health, DHHS' Cultural and Linguistically Appropriate Services Guidelines, which is available at: http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53, and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Medicaid enrollees.

l. The MCO must ensure that:

i. Marketing materials are distributed statewide.

ii. The MCO does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

iii. The MCO does not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

2. Marketing Plan

a. The MCO must develop and implement a plan detailing the marketing activities it will undertake and materials it will create during the contract period, which must incorporate the requirements of this RFP. The detailed, proposed plan must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date.

b. The MCO must not begin member marketing activities associated with this contract prior to approval of the marketing plan by MLTC.

c. The plan must include at a minimum:

i. Stated marketing goals and strategies.

ii. A marketing calendar, which begins with the date of the signed contract between MLTC and the MCO, and runs through the first calendar year of providing services to Medicaid members, that addresses all marketing areas, including advertising plans, website development and launch plans, printed materials, material distribution plans (including specific locations), or outreach activities (health fairs, area events, etc.).

iii. A summary of value-added benefits to be used by MLTC to create a plan comparison chart to assist Medicaid enrollees in selecting the MCO that best meets their needs.

iv. Distribution methods and schedules, including media schedules for electronic or print advertising (including date and station or publication).

v. How the MCO plans to meet the informational needs, relative to marketing (for prospective enrollees), of the physical and cultural diversity within the State. This may include but is not limited to: a description of the provisions for non-English speaking prospective enrollees, interpreter services, or alternate communication mechanisms (such as sign language, Braille, audio tapes, etc.).

vi. A list of all subcontractors engaged in marketing activities for the MCO.

vii. A copy of the training curriculum for marketing representatives (internal staff and subcontractors).

viii. The MCO's procedure for monitoring and enforcing compliance with all marketing guidelines, in particular the monitoring of prohibited marketing methods, among internal staff and subcontractors.

ix. Copies of all marketing materials (print and multimedia) that are directed at Medicaid enrollees planned for distribution by the MCO or any of its subcontractors.

x. Copies of marketing materials that are: (1) currently in concept form, but not yet produced, including a detailed description, or (2) samples from other states that will be duplicated in a similar manner for the Nebraska Medicaid managed care population.

xi. Details of proposed marketing activities and events.

xii. Details regarding the basis it uses for awarding bonuses or increasing the salary of marketing representatives or any other employees involved in marketing activities.

xiii. Details about supplying current materials, as well as plans to remove outdated materials, from public areas.

xiv. The MCO's protocols for responding to unsolicited direct contact (verbal or written) from a Medicaid enrollee or potentially eligible individual. This should include circumstances that will:

a) Initiate referral to the enrollment broker.

b) Initiate referral to the Medicaid Eligibility customer service line.

c) Terminate the conversation.

d. Any changes to the marketing plan, included materials or activities, must be submitted to MLTC for review and approval a minimum of 45 calendar days before intended implementation of the marketing activity.

e. The plan shall be updated quarterly and submitted to MLTC for dissemination to the Medical Assistance Advisory Committee for review, in accordance with 42 CFR 431.12.

3. Allowable Marketing Activities

a. The MCO and its subcontractors are permitted to perform the following activities:

i. Distribute general information through mass media (i.e., newspapers, magazines, and other periodicals; radio; television; the internet; public transportation advertising; billboards; and, any other media outlets), in compliance with prohibitions to placement detailed in this RFP.

ii. Make telephone calls and home visits to members currently enrolled in the MCO (member education and outreach), for the purpose of educating them about services offered by or available through the MCO.

iii. Respond to verbal or written requests for information made by Medicaid enrollees, in compliance with the marketing plan approved by MLTC.

iv. Provide promotional giveaways which do not exceed $15.00 in value, to current members; persons not currently members cannot receive promotional giveaways from the MCO.

v. Attend or organize activities that benefit the entire community, such as health fairs or other health education and promotion activities. MLTC must be notified of the activity and details must be provided about the planned marketing activities using the process described in this RFP.

vi. Attend activities at a business only at the invitation of the entity. MLTC must be notified in advance of the activity and details must be provided.

vii. Attend events at the request of MLTC to disseminate or share information about the MCO, its services and outcomes.

viii. Conduct telephone marketing only during incoming calls from Medicaid enrollees. The MCO may return telephone calls to potential members only when requested to do so by the caller. The MCO must utilize the response plan outlined in the marketing plan during these calls, as approved by MLTC.

ix. Send plan-specific materials to Medicaid enrollees only at their request.

b. If there is any instance in which a MCO-allowable activity conflicts with a prohibited activity, the prohibited activity guidance must be followed.

4. Prohibited Marketing Activities

The MCO and its subcontractors are prohibited from engaging in the following activities:

a. Marketing directly to Medicaid enrollees or potentially Medicaid eligible individuals, including persons currently enrolled in Medicaid or other MCOs. Direct marketing includes direct mail advertising; unsolicited email ("spam"); and, door-to-door, telephonic, or other "cold call" marketing techniques.

b. Asserting that the MCO is endorsed by CMS, the Federal or State government, MLTC, or any similar entity.

c. Distributing plans and materials or making any statement (written or verbal) that MLTC determines to be inaccurate, false, confusing, misleading, or intended to defraud members or MLTC. This includes statements that mislead or falsely describe covered services, membership or availability of providers, or qualifications or skills of providers.

d. Portraying competitors or potential competitors in a negative manner.

e. Assisting with enrollment or improperly influencing MCO selection.

f. Inducing or accepting a member's enrollment or disenrollment from any Medicaid enrollee or member not currently enrolled with the MCO;

g. Using the seal of the State of Nebraska, or MLTC's name, logo, or other identifying marks on any materials produced or issued, without the prior written consent of MLTC.

h. Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage, or that MCOs or a particular MCO is the only provider of Medicaid services and the potential enrollee must enroll in the MCO or MCOs to obtain benefits or not lose benefits.

i. Comparing itself to another organization/MCO by use of the other's name.

j. Sponsoring or attending any marketing or community health activities or events without notifying MLTC within the timeframes specified in this RFP.

k. Engaging in any marketing activities, including unsolicited personal contact with a Medicaid enrollee or potentially eligible individual, at an employer-sponsored enrollment event when employee participation is mandated by the employer.

l. Marketing or distributing marketing materials, including member handbooks, or soliciting members in any other manner, inside, at the entrance, or within 100 feet of DHHS local offices without prior approval from MLTC. Medicaid eligibility office staff or approved MLTC agents are the only authorized personnel to distribute such materials.

m. Conducting marketing or distributing marketing materials in hospital ERs, including the ER waiting areas, patient rooms, or treatment areas.

n. Registering or asserting any copyright or releasing any report, graph, chart, picture, or other document relating to services provided under this contract, without the prior written consent of MLTC.

o. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligible individuals from third-party vendors, including providers and state offices.

p. Using raffle tickets, event attendance, or sign-in sheets to develop mailing lists of prospective members.

q. Charging members for good or services distributed at events.

r. Charging members a fee for accessing the MCO website.

s. Influencing enrollment in conjunction with the sale or offering of any private insurance.

t. Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the MLTC-designated enrollment broker, for enrollment.

u. Referencing the private insurance component of the MCO, if any, in any of its Medicaid MCO enrollee marketing materials.

v. Using terms in marketing materials such as “choose,” “pick,” “join,” etc., unless the marketing materials include the enrollment broker’s contact information.

5. Media Contacts

The MCO must not provide information to the media or give media interviews without the prior consent of MLTC. Any contacts by the media or other entity or individual not directly related to the program must be referred to MLTC.

6. Provider Marketing Guidelines

a. When conducting any form of marketing in a provider’s office, the MCO must obtain and keep on file the written consent of the provider.

b. The MCO shall not require its providers to distribute MCO-prepared marketing communications to their patients.

c. The MCO shall not provide incentives or giveaways to providers to distribute them to MCO members or potential MCO members.

d. The MCO shall not allow providers to solicit enrollment or disenrollment in a MCO, or distribute MCO-specific materials at a marketing activity.

e. The MCO shall not provide printed materials to providers with instructions detailing how to change MCOs to members of other MCOs.

f. The MCO must instruct participating providers regarding the following communication requirements:

i. Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they contract.

ii. Participating providers may display and distribute health education materials for all contracted MCOs or they may choose not to display and distribute for any contracted MCOs. Health education materials must adhere to the following guidance:

a) Health education posters cannot be larger than 16 x 24 inches.

b) Children’s books, donated by MCOs, must be in common areas.

c) Materials may include the MCOs name, logo, telephone number and website address.

d) Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

iii. Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom/which the provider has a contract.

iv. Providers may display MCO participation stickers, but if they do they must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs.

v. MCO stickers indicating that the provider participates with a particular MCO cannot be larger than 5 x 7 inches and cannot indicate anything more than “the MCO is accepted or welcomed here”.

vi. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, providers may not recommend one MCO over another, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone, or a computer in the office.

vii. On actual termination of a contract with the MCO, a provider who/that has contracts with other MCOs may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Providers must continue to see current patients enrolled in the MCO through the termination date, according to all terms and conditions specified in the contract between the provider and the MCO.

viii. MCOs must not produce branded materials instructing members about how to change to a different MCO. They must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance

H. GRIEVANCES AND APPEALS

1. General Requirements

a. The MCO must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State’s fair hearing system. The MCO must distinguish between a grievance, grievance system, and grievance process, as defined below:

i. A grievance is a member’s expression of dissatisfaction with any aspect of care other than the appeal of actions.

ii. The grievance system includes a grievance process, an appeal process, and access to the State’s fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process.

iii. A grievance process is the procedure for addressing members’ grievances.

b. The MCO must:

i. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.

ii. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.

iii. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member’s grievance must be a health care professional with clinical expertise in treating the member’s condition or disease if any of the following apply:

a) The denial of service is based on lack of medical necessity.

b) Because of the member’s medical condition, the grievance requires expedited resolution.

c) The grievance or appeal involves clinical issues.

iv. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.

v. Provide access to MLTC and/or its designee for any information related to grievances or appeals filed by its members. MLTC will monitor enrollment and termination practices to ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR 438.226-228.

2. Complaint and Grievance Processes

a. A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.

b. A member may file a grievance with the MCO or the State at any time.

c. The MCO must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the MCO receives the grievance.

d. MLTC will establish the method the MCO must use to notify a member of the disposition of a grievance.

3. Service Authorizations and Notices of Action

a. Service Authorization

i. The MCO must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.

ii. The MCO must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

b. Notice of Adverse Action

i. The MCO must notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404.

ii. The MCO must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:

a) The action the MCO or its subcontractor has taken or intends to take.

b) The reason(s) for the action.

c) The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

d) The member's or the provider's right to file an appeal.

e) The member's right to request a State fair hearing.

f) Procedures for exercising a member's rights to appeal or grieve a decision.

g) Circumstances under which expedited resolution is available and how to request it.

h) The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.

iii. The notice must be in writing and must meet the language and format requirements described in Section IV.F Member Services and Education.

c. Timeframes for Notice of Action

i. The MCO must provide notice to the member a minimum of ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified.

iii. The MCO must give notice by the date of the action under the following circumstances:

a) The death of a member.

b) A signed written member statement requesting service termination or giving information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services.

c) The member's admission to an institution where he or she is ineligible for further services.

d) The member's address is unknown and mail directed to him/her has no forwarding address.

e) The member has been accepted for Medicaid services by another state.

f) The member's physician prescribes the change in the level of medical care.

g) An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1989.

h) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 calendar days (applies only to adverse actions for nursing facility transfers).

iv. The MCO must provide notice on the date of action when the action is a denial of payment.

v. Standard Service Authorization Denial

vi. The MCO must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed 14 calendar days following receipt of the request for service. The timeframe may be extended up to 14 additional calendar days if the member or the provider requests an extension or the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the MCO extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The MCO must issue and carry out its determination as expeditiously as the member's health condition requires and in any event no later than the date the extension expires.

vii. Expedited Service Authorization Denial

For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to

attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the time period by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and the reason(s) why the extension is in the member's interest.

viii. Untimely Service Authorization Decisions

The MCO must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.

4. Appeal Processes

a. A member may file a MCO-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.

b. The member or provider may file an appeal within 90 calendar days from the date on the MCO's Notice of Action.

c. The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.

d. The MCO must:

i. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.

ii. Ensure that there is only one level of appeal for members.

iii. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

iv. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination.

v. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.

e. The MCO must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within 45 calendar days from the day the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the MCO must:

i. Make reasonable efforts to give the member prompt verbal notice of the delay.

ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if s/he or she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

f. The MCO must provide written notice of disposition, which must include:

i. The results and date of the appeal resolution; and

ii. For decisions not wholly in the member's favor:

a) The right to request a state fair hearing.

b) How to request a state fair hearing.

c) The right to continue to receive benefits pending a hearing.

d) How to request the continuation of benefits.

e) If the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.

5. Expedited Appeals Process

a. The MCO must establish and maintain an expedited review process for appeals that the MCO determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.

b. The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.

c. The MCO must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.

d. The MCO must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than 72 hours after the MCO receives the appeal. The MCO may extend the timeframes by up to 14 calendar days if the member requests the extension or the MCO shows that there is need for additional information and the reason(s) why the delay is in the member's interest.

e. For any extension not requested by the member, the MCO must give the member written notice of the reason for the delay.

f. In addition to written notice, the MCO must also make reasonable efforts to provide verbal notice of resolution.

g. The MCO must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.

h. If the MCO denies a request for expedited resolution of an appeal, it must:

vi. Transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCO receives the appeal with a possible extension of 14 calendar days.

vii. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.

6. Continuation of Benefits

a. The MCO must continue a member's benefits if any one of the following apply:

i. The appeal is filed timely, meaning on or before the later of the following:

a) Ten (10) calendar days after the MCO mailing the Notice of Action; or

b) The intended effective date of the MCO's proposed action.

ii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

iii. The services were ordered by an authorized provider.

iv. The authorization period has not expired.

v. The member requests an extension of benefits.

b. If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

vi. The member withdraws the appeal.

vii. The member does not request an appeal within ten (10) calendar days from when the MCO mails an adverse MCO decision.

viii. A state fair hearing decision adverse to the member is made.

ix. The authorization expires or authorization service limits are met.

c. The MCO may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCO action.

7. Access to State Fair Hearings

a. A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a state fair hearing only after receiving notice that the MCO is upholding the adverse benefit determination.

b. If the MCO takes action and the member requests a state fair hearing, the State must grant the member a state fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the MCO.

c. The member or the member's representative (if any) may request a state fair hearing within 90 calendar days from the date of the MCO Notice of Action.

d. The parties to the State fair hearing include the MCO, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.

e. The State must ensure that any member dissatisfied with a determination denying a member's request to transfer plans/disenroll is given access to a State fair hearing.

8. Reversed Appeals

a. If the MCO or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but in no event later than 72 hours from the date the MCO receives notice reversing the determination.

b. The MCO must pay for disputed services if the MCO or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

9. Grievance and Appeal Recordkeeping Requirements

The MCO must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.

b. The date the grievance or appeal was received.

c. The date of each review or, if applicable, review meeting.

d. Resolution at each level of the appeal or grievance process, as applicable.

e. Date of resolution at each level of the appeal or grievance process, as applicable.

f. Name of the covered person by or for whom the appeal or grievance was filed.

The MCO is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.

10. Information to Providers and Subcontractors

The MCO must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract:

a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing.

b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.

c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings.

d. The toll-free number(s) to use to file verbal grievances and appeals.

e. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending.

f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

11. Reporting of Complaints, Grievances, and Appeals

The MCO is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals. MLTC reserves the right to extend the monthly reporting requirement at its sole discretion. This information will be used by MLTC to measure the MCO's performance.

I. PROVIDER NETWORK REQUIREMENTS

1. General Provider Network Requirements

a. The network must be supported by written contracts between the MCO and its providers.

b. The MCO must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the provider serves only the Medicaid population.

c. There must be sufficient providers for the provision of medically necessary covered services, including emergency medical care, at any time.

d. The MCO must have available non-emergent after-hours physician or primary care services within its network.

e. Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and

time are fully outlined in Attachment 2 - Access Standards. The MCO must ensure that providers are available within these requirements.

f. The MCO's network providers must comply with all requirements set forth in this RFP.

g. The MCO must take corrective action if it, or its providers, fail to comply with the timely access requirements in this section and Attachment 2 – Access Standards.

h. The MCO must make a good faith effort to contract with urgent care centers in the State to maximize availability of urgent care services to its members. In the event that a contract cannot be obtained, the MCO must maintain documentation detailing the efforts it has made.

i. In order to ensure members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the MCO must not have a contract arrangement with any provider in which the provider agrees that it will not contract with another MCO, or in which the MCO agrees that it will not contract with another provider. The MCO must not advertise or otherwise hold itself out as having an exclusive relationship with any provider.

j. In all its contracts with health care professionals, the MCO must comply with the requirements specified in 42 CFR 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.

k. The MCO must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, and provide for interpreters in accordance with 42 CFR 438.206(c)(2).

l. The MCO must have adequate capacity within its network to communicate with members in Spanish and other languages, when necessary, as well as with those individuals who are deaf or hearing-impaired.

m. The MCO must consider the ability of providers to ensure physical access, accommodations, and accessible equipment for Medicaid members with physical, developmental, or mental disabilities.

2. Provider Discrimination Prohibition

a. A MCO may not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider who/that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification.

b. MCO provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

c. If a MCO declines to include individual or group providers in its network, it must give the affected providers written notice of the reason for its decision. Federal requirements at 42 CFR 438.12(b) shall not be construed to:

i. Require the MCO to contract with providers beyond the number necessary to meet the needs of its members.

ii. Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

iii. Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to its members.

3. Mainstreaming of Members

a. To ensure mainstreaming of Nebraska Medicaid members, the MCO must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency),

ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The MCO must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors do the same.

Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f):

i. Denying or not providing a member any covered service or access to an available facility.

ii. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary.

iii. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.

iv. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.

b. If the MCO knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCO shall be subject to intermediate sanction or contract termination.

c. If the MCO identifies a problem involving discrimination by one of its providers, it must promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures shall subject the MCO to intermediate sanction or contract termination.

4. Establishing the Network

a. The MCO must offer an appropriate range of preventive, primary care, and specialty services adequate for the number of its members. The MCO must submit documentation to MLTC, in a format approved by MLTC, to demonstrate it meets this requirement at contract start date and any time there is a significant change (as defined by the State) in the MCO's operations that impacts services.

b. The MCO's network must include a sufficient number/type of providers to meet MLTC access standards for adequate capacity for adult and pediatric primary care providers (PCPs); high-volume specialties (cardiology, neurology, hematology/ oncology, obstetrics and gynecology, and orthopedic physicians); behavioral health; and, urgent care centers, FQHCs, RHCs, and pharmacies. The MCO must also contract with additional specialties (allergy, dermatology, endocrinology, gastroenterology, general surgery, neonatology, nephrology, neurosurgery, occupational therapy, ophthalmology, otolaryngology, pathology, physical therapy, pulmonology, psychiatry, radiology, reconstructive surgery, rheumatology, urology, and pediatric specialties); hospitals; and additional provider types to meet its members' needs.

c. The MCO must provide an adequate network of (PCPs) to ensure that members have access to all primary care services in the benefits package. All members must be allowed the opportunity to select or change their PCP. Provider types that can serve as PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and physician assistants may also serve as PCPs when they are practicing within the scope and requirements of their license.

d. The MCO must maintain a network of qualified providers that meets appointment availability and geographic access standards defined in Attachment 2 – Access Standards and all requirements in this section. Attachment 3 – Nebraska Counties Classified by Urban/Rural/Frontier Status provides a map of Nebraska counties classified by urban, rural, and frontier status, as this classification is referenced in the access standards.

e. The MCO's network must include providers that are currently serving Medicaid members and will need to be part of the MCO's network to continue to care for these members. In addition, the MCO must make a good faith effort to include providers currently contracted with behavioral health regions in Nebraska.

f. The MCO must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care, if that source is not a women's health specialist.

g. For members who meet SHCN criteria, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

h. The MCO must ensure that its provider network includes sufficient numbers of network providers with experience and expertise regarding the following behavioral health conditions:

i. Co-occurring mental health and substance use disorders.

ii. Co-occurring mental health and substance use disorders and developmental disabilities.

iii. Serious and persistent mental illness.

iv. Severe emotional disturbance among children and adolescents, including coordinated care for children served by multiple state agencies (e.g., Child Welfare, Probation, Developmental Disabilities, etc.).

v. Sex-offending behaviors.

vi. Eating disorders.

vii. Co-occurring serious mental illness (SMI) and common chronic physical illnesses.

i. The MCO must contract with providers who/that demonstrate a commitment to the behavioral health principles of care defined in Section IV.L Care Management of this RFP, including principles of rehabilitation and recovery from mental illness and substance use disorder; a focus on recovery-oriented, trauma-informed services and trauma-specific treatment (e.g., trauma-focused cognitive behavioral therapy); consumer and family involvement in program management and oversight; a family-driven and strengths-based approach to working with children and their families; cultural and linguistic competency; and training for staff about these principles. In addition, the MCO must collaborate with the DHHS Division of Behavioral Health and State behavioral health regions in establishing its network.

j. The MCO's provider network must be submitted to the State, via the provider enrollment file, a minimum of 90 calendar days prior to the contract's start date. A list of Medicaid eligible providers will be provided by MLTC.

k. If any service or provider type is not available to a member within the mileage radius specified in Attachment 2 – Access Standards, the MCO must submit to MLTC, for approval a minimum of 45 calendar days prior to implementation, verification that the covered services are not available within the required distance.

l. The MCO is not precluded from making arrangements with a provider outside the State for members to receive a higher level of skill or specialty than the level that is available within the State.

5. Contracting with FQHCs and RHCs

A MCO must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the MCO and a FQHC or RHC, the MCO must notify MLTC.

6. Adequate Capacity

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

a. Its anticipated Medicaid enrollment.

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

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

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

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

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

7. Patient-Centeredness/Patient-Centered Medical Homes

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

b. Requirements of a PCMH include:

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

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

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

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

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

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

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

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

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

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

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

ii. Recovery support services.

iii. Natural community supports for members and their families.

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

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

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

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

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

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

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

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

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

8. Pharmacy Network

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

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

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

calendar days prior to its intended implementation. Changes to the specialty drug list must also be reviewed and approved by MLTC. Specialty drugs are defined in the Glossary section of this RFP.

d. The MCO may utilize mail-order pharmacies in its network, but must not require or incentivize members to use a mail-order pharmacy, including through different member copays. Members who opt to use this service must not be charged fees, including postage and handling fees.

e. The MCO must not designate preferred pharmacies within its network or offer incentives to members to use a designated pharmacy. The MCO must not incorporate branding of any pharmacy onto member ID cards.

9. Clinical Laboratory Improvement Amendments Requirements

In compliance with the Clinical Laboratory Improvement Amendments (CLIA) and the requirements of 42 CFR 493, Subpart A, MLTC requires all clinical laboratories to provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver during the provider registration process. Failure to do so will result in either a termination of an active provider identification number or denial of initial registration. These requirements apply to all clinical laboratories. Pass-through billing or other activities conducted with the intent of avoiding these requirements is prohibited. The MCO may not reimburse providers who do not comply with the above requirements.

10. Appointment Availability and Referral Access Standards

a. Nebraska's appointment availability standards are included in Attachment 2 – Access Standards. MLTC will monitor each MCO's compliance with these standards through regular reporting per Attachment 6 – Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.

b. Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.

c. Follow-up to emergency room visits must be available in accordance with the attending provider's discharge instructions.

d. Direct contact with a qualified MCO clinical staff person must be available to members through a toll-free telephone number at any time. The MCO may not require a PCP referral for appointments with behavioral health providers when the behavioral health providers are in the MCO's network.

e. The MCO is responsible for monitoring and assuring provider compliance with appointment availability standards and provision of appropriate after-hour coverage.

f. The MCO must have processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, MLTC may require that they be implemented by the MCOs.

g. The MCO must monitor the practice of placing members who seek any covered services on waiting lists. If the MCO determines that a network provider has established a waiting list and the service is available through another network provider, the MCO must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider. In circumstances in which the member requires residential behavioral health services and is placed on a waiting list, the MCO must require its providers to offer interim services until residential services are available.

11. Geographic Access Standards

a. The MCO must comply with maximum travel times and/or distance requirements per Attachment 2 – Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.

b. If there are gaps in the MCO's provider network, the MCO must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the MCO must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.

c. The MCO must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The MCO must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.

12. Provider Outreach and Application Processing

a. The MCO must develop standardized provider application/credentialing forms and provider contracts for use with all providers, and utilize standardized processes.

b. The MCO is required to submit its provider contract template(s) to MLTC with its proposal.

c. The MCO must notify MLTC, a minimum of 15 calendar days in advance, if it decides no longer to accept provider applications for primary care or a certain specialty because member needs and MLTC access standards are being met otherwise. The MCO must also notify MLTC a minimum of 15 calendar days in advance of resuming acceptance of those provider applications.

13. Provider Enrollment in Medicaid

a. The MCO must require that all of its contracted providers enroll with MLTC as an approved service provider. For specific requirements on provider enrollment, refer to the MLTC website at: http://MLTC.ne.gov/medicaid/Pages/med_providerenrollment.aspx.

b. The MCO must begin its credentialing process concurrently with a provider's Medicaid provider enrollment rather than delaying its credentialing process until MLTC has approved a provider's enrollment in Medicaid.

14. Provider Credentialing and Re-Credentialing

a. The MCO is required to establish and implement written policies for the selection and retention of providers, consistent with provider credentialing and re-credentialing requirements of applicable law and to submit these policies to MLTC for approval.

b. The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must:

i. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or

ii. Deny the application and ensure that the provider is not used by the MCO. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

c. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

d. If the MCO delegates credentialing to a subcontractor, the MCO must obtain MLTC approval of (a) the subcontractor and (b) the credentialing process, including components delegated to the MCO's subcontractor. The MCO must require that all licensed medical professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC retains final approval of the credentialing subcontractor and process.

e. The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. The MCO must also accept any standardized provider credentialing

form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.

f. The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.

g. The MCO must re-credential each provider a minimum of every three (3) years, at a minimum, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information.

h. The MCO must communicate with MLTC, DHHS Division of Behavioral Health, and DHHS Division of Public Health regarding incidents or audits that potentially affect provider licensure for any applicable provider types.

i. As part of its credentialing process, the MCO must require each provider entity to disclose the following information in accordance with 42 CFR 455.104:

i. The name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

ii. Whether any of the persons named is related to another as spouse, parent, child, or sibling.

iii. The name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

a) Keep copies of all requests and responses.

b) Make those requests and responses available to MLTC upon request.

c) Advise MLTC when there is no response to a request.

15. Network Administration

a. The MCO must maintain and continually update its network provider database that contains, at a minimum, the following information for each network provider:

i. Network provider name

ii. Contracted services

iii. Site address(es) (street address, city, zip code, region of the State)

iv. Site telephone numbers

v. Site hours of operation

vi. Emergency/after-hours provisions

vii. Professional qualifications and licensing;

viii. Areas of specialty, including specialties related to behavioral health conditions

ix. Cultural and linguistic capabilities

x. Malpractice insurance coverage and malpractice history

xi. Credentialing status

b. The MCO must have the capability to produce a list of network providers, sorted by type of service and by providers' capability to communicate with members in their primary languages. This list must be available to the MCO's clinical staff at all times, and available to network providers and other interested parties upon their request and at no charge. As described in the Member Services section of this RFP, this list must be available on the MCO's website and updated in real time.

16. Network Development Plan

a. The MCO must submit to MLTC a network development plan with its proposal. This plan should demonstrate the MCO's capability of developing a network within the State. While this RFP does not require or promote the solicitation of letters of intent from potential network providers, the MCO shall demonstrate its track record in building networks in the State or other markets, particularly for Medicaid or other public-payer products. The MCO may also describe its efforts to become more familiar and develop relationships with Nebraska providers.

b. From the date of contract award and then every two weeks until the contract effective date, the MCO shall provide updates about its network development activities. This plan must detail the MCO's network status, including GeoAccess reports, and describe any provider network gaps and the MCO's remediation plans.

c. Future network development plans must be submitted by November 1st of each contract year. This document is an assurance of the adequacy and sufficiency of the MCO's provider network. The MCO must also submit, as needed, an updated plan when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, payments, or eligibility of a new population.

d. The MCO must include in its stated future plans a narrative and statistical analysis consistent with the MLTC assessment methodology. At a minimum, the analysis must be derived from:

i. Quantitative data, including performance of appointment standards/appointment availability, eligibility/enrollment data, utilization data, network inventory, demographic (age/gender/race/ethnicity) data, and the number of single case contracts by service type.

ii. Qualitative data (including outcomes data), when available, including grievance information; concerns reported by eligible or enrolled members; grievances, appeals, and requests for hearings data; member satisfaction survey results; and, prevalent diagnoses.

iii. Status of provider network issues within the prior year that were significant or required corrective action by the MCO, including findings from the MCO's annual operational review.

iv. A summary of network development efforts conducted during the prior year.

v. Plans to correct any current material network gaps and barriers to network development.

vi. Priority areas for network development activities for the following year, goals, action steps, timelines, performance targets, and measurement methodologies for addressing priorities.

vii. The participation of members, family members/caretakers, providers, including State-operated providers, and other community stakeholders in the annual network planning process.

e. The MCO's network development plan must be submitted to MLTC for approval. The MCO must submit periodic progress reports as requested by MLTC.

17. Provider Network Policies and Procedures

a. The MCO must have policies about how it will:

i. Communicate with the network regarding contractual and/or program changes and requirements.

ii. Monitor network compliance with State rules, MLTC policies, and MCO policies, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring a member's care is not compromised during the grievance/appeal processes.

iii. Evaluate the quality of services delivered by the network.

iv. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

v. Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.

vi. Process provisional credentials for behavioral health service providers.

vii. Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling.

viii. Provide training for its providers and maintain records of such training.

ix. Educate its provider network regarding appointment time requirements.

x. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

b. All policies and procedures must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to intended implementation.

c. The MCO must notify providers and members of impending policy changes a minimum of 45 calendar days prior to implementation.

J. PROVIDER SERVICES

1. Provider Services

The MCO must have a provider services function to provide support and assistance to all its providers. This function must, at a minimum:

a. Be available Monday through Friday from 7:00 am to 8:00 pm (central time) to address non-emergency provider issues and on an anytime basis for non-routine prior authorization requests and emergent provider and pharmacy issues.

b. Have clinical pharmacists available Monday through Friday, 8:00 am to 8:00 pm (central time), for clinical questions and prior authorization processing.

c. Ensure each MCO provider is provided all rights outlined in the MCO's provider handbook.

d. Provide ongoing provider training, respond to provider inquiries, and provide general assistance to providers regarding program operations and requirements.

e. Make regularly scheduled visits to provider sites, as well as ad-hoc visits as appropriate.

2. Provider Toll-Free Telephone Line

a. The MCO must operate a toll-free telephone line to respond to provider questions, comments, inquiries, and complaints. A separate line or menu option must be dedicated to pharmacy and prescription issues, including member copayments, if applicable.

b. The MCO must ensure that provider calls are acknowledged and resolved within three (3) business days of receipt. If the issue cannot be resolved within three (3) business days, the MCO must notify the provider of the expected resolution timeframe, which shall not exceed 30 business days (including referrals from MLTC).

c. The MCO's call center system must have the capability to track provider call management metrics.

d. After normal business hours, the provider services toll-free telephone line must include recorded information regarding normal business hours and instructions about how to verify enrollment for any MCO member with an emergent or urgent medical condition. However, a provider does not have to obtain verification before providing ED services and care.

e. The MCO must measure and monitor the accuracy of responses provided by call center staff and report this monthly to MLTC. Corrective action must be taken by the MCO as necessary to ensure the accuracy of responses by staff.

f. Call center staff must have access to electronic documentation from previous calls made by or on behalf of the member to the MCO's information line(s).

3. Provider Handbook

a. The MCO must submit a provider handbook to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date. The approved handbook must be available on the MCO website within ten (10) calendar days of its approval by MLTC. The MCO may choose not to distribute the handbook by regular mail as long as it provides written notification to providers that it is available online and includes details about how the provider may request a printed copy at no charge to the provider. The provider handbook must include, but is not limited to, the following:

i. Description of the MCO and its corporate entity.

ii. Services and benefits provided by the MCO, including core services and value-added services.

iii. Emergency service responsibilities.

iv. Confidentiality provisions.

v. Process for verifying a member's enrollment in the MCO.

vi. Medical necessity standards as defined by MLTC and the MCO.

vii. Practice guidelines and protocols.

viii. Network provider credentialing process and criteria.

ix. Medical record standards.

x. MLTC's standards for geographic access and appointment availability.

xi. Mainstreaming requirements.

xii. Utilization management requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services.

xiii. Clinical criteria for admission, continued stay, and discharge for each covered service.

xiv. Reporting requirements for serious reportable events and reportable adverse incidents.

xv. Use of MLTC preferred drug list.

xvi. Pharmacy payer sheet.

xvii. Compound prescription requirements.
xviii. Prospective DUR response requirements.

xix. Paper and electronic claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim, along with samples of clean and complete claims.

xx. Policies and procedures detailing the provider complaint system including, but not limited to, specific instructions about how to contact the MCO to file a provider complaint, the timelines allowed for resolution, and the procedure for escalation of unresolved disputes.

xxi. Policies and procedures for the MCO's Grievance System, including information about how the provider may file a grievance or appeal on a member's behalf with written permission.

xxii. Process for appealing payment and service denial decisions.

xxiii. Procedures for using web-based provider services.

xxiv. Call center number(s) and hours.

xxv. Names and contact information of provider services staff.

xxvi. MCO prompt pay requirements.

xxvii. Information regarding the MCO's chronic care and disease management programs, including instruction about making referrals.

xxviii. Quality performance standards and requirements.

xxix. Expectations for PCPs.

xxx. Provider rights and responsibilities.

b. The MCO must:

i. Modify or supplement the provider handbook by distributing periodic notices to network providers.

ii. Review the handbook a minimum of bi-annually and amend it, if necessary, in consultation with MLTC and (as appropriate) its members, their families, providers, and other stakeholders.

iii. Redistribute the amended portions of the handbook to network providers through a clear change process.

4. Provider Website

a. The MCO must have a provider website. It may be developed within the MCO's existing website (such as a portal) to meet these requirements. The MCO must post up-to-date and accurate information and documents to its provider website. MLTC may request that any information be added, removed, or altered that it determines is inaccurate, misleading, or is any way contrary to the objectives of this contract.

b. The MCO provider website must include general and up-to-date information about the MCO as it relates to the Nebraska Medicaid program. All information must be searchable, and include, but is not limited to:

i. MCO provider handbook and all MCO policies and procedures.

ii. MCO-relevant MLTC bulletins.

iii. Limitations on provider marketing.

iv. Information on upcoming provider trainings.

v. Provider training manuals.

vi. Information about the provider and member grievance system.

vii. Information about obtaining prior authorizations and referrals.

viii. MCO formulary (list of covered medications) and the Nebraska PDL.

ix. MCO pharmacy prior authorization requirements.

x. Updated MCO MAC pricing.

xi. Instructions regarding how and whom to contact for questions about filling prescriptions.

xii. Information about how to contact the MCO's Provider Services staff.

xiii. A link to the MLTC website and other related websites.

xiv. A link to the MCO's corporate website.

xv. MLTC-approved formulary changes and prior authorization requirements, clinical criteria, and revisions a minimum of 30 calendar days prior to the effective date of the requirement or revision.

c. The MCO must, in collaboration with MLTC, determine which program content shall be published on the website. The MCO's website must provide web-enabled transactional capabilities. These capabilities must include, but are not limited to:

i. Provider/member inquiries.

ii. Submission of initial authorization and other requests.

iii. Web-based referral search system that will allow MCO and MLTC staff, providers, members, and any other interested persons to locate network providers through an online searchable database. The searchable database must include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and demographic information.

d. The MCO provider website is considered marketing material, and must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

e. The MCO must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing any member eligibility or identification information on the website.

f. The MCO website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability an issue.

g. The MCO must ensure that the website is maintained with accurate and current information and is compliant, at all times, with the requirements of this RFP.

5. Provider Outreach, Education, and Training

a. The MCO must provide training to all providers and their staff regarding the requirements of the contract, including limitations on provider marketing, identification of special needs of members (including the LTSS population), and the appropriate utilization of emergency room services, including for behavioral health emergencies. The MCO must make initial training available within 30 calendar days of contracting with a provider.

b. The MCO must also conduct ongoing training throughout the duration of this contract, as deemed necessary by the MCO or MLTC, in order to ensure compliance with program standards and the contract. Training sessions must include, but not be limited to:

vi. Face-to-face and tele- or web-conference training sessions

vii. Recorded provider training sessions on or available from the MCO's website

viii. Training and education for nursing facilities regarding billing procedures for when a member transitions from a skilled to a custodial level of care.

ix. Documentation of training sessions and attendance, available to MLTC on request.

c. The MCO must submit a copy of the provider training handbook and training schedule to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date. Any changes to the handbook must be submitted to MLTC a minimum of 45 calendar days prior to scheduled changes and dissemination of such changes.

d. The MCO must develop and offer specialized initial and ongoing training in billing procedures, service authorization requirements, and other procedures it deems appropriate for network providers who/that have traditionally billed and obtained service authorization primarily from Medicaid or Medicare only or who/that are new to the integrated managed care contracts, including behavioral health providers and pharmacists. MLTC shall be advised of these sessions and appropriate staff shall be allowed to attend at their discretion.

e. The MCO must develop, establish, and maintain a provider advisory committee. The committee must have representation from the major provider organizations in the State, as well as individual providers, including behavioral health and pharmacy providers, as well as providers who primarily serve individuals with disabilities. Whenever feasible, MCO staff shall work collaboratively with the provider advisory committee, as well as established provider organizations, to create network development and management strategies and procedures. In addition, the MCO must establish a behavioral health advisory committee to provide input to the provider advisory committee.

f. The MCO must meet with providers and provider associations on a regular basis and at various locations throughout the State. In addition, the MCO must hold a provider forum no less frequently than quarterly, at various locations across the State. The forums must be facilitated by the MCO's Administrator/CEO or designee. The purpose of the forums is to improve communication between the MCO and its providers. The forums must be open to all providers within the MCO's network. The forums must not be the only venue by which the MCO communicates and participates in a discussion and review of the issues affecting its provider network. Provider forum meeting agendas and minutes must be made available to MLTC on request. The MCO must report information discussed during these meetings and forums to the MCO's executive management and MLTC.

6. Collaboration with Network Providers

a. The MCO must promote ongoing and seamless communication between providers and the MCO. To accomplish this task, the MCO must:

i. In addition to establishing and working collaboratively with the provider advisory committee, include provider representatives in the MCO's committee structure, to give providers a direct voice in developing and monitoring clinical policies and operational issues.

ii. Work with providers to improve administrative efficiencies through the use of the MCO's website, information technology, and other strategies identified through provider meetings and on-site visits.

iii. Provide encryption software on request from a provider to allow the exchange of member data via email.

iv. Provide a monthly newsletter that includes articles covering topics of interest for all provider types. This newsletter must be posted to the MCO's website.

b. The MCO must identify a provider network liaison, who will work collaboratively with the provider advisory committee to establish the process for responding to provider concerns; develop provider trainings in response to identified needs or changes in protocols, processes, and forms; and, enhance MCO-provider communication strategies.

c. Throughout the term of the contract, the MCO must alert providers to modifications in the provider handbook and to changes in provider requirements that are not otherwise communicated by MLTC. To accomplish this task the MCO must:

i. Request and obtain from providers an email address, so they can be alerted to access the MCO's website to download updates to the provider handbook and provider requirements.

ii. Email providers and publish on the MCO's website any policy clarification not otherwise communicated by MLTC.

iii. Post notification of policy and procedural changes on the MCO's website. Advance notification to members and providers of changes that will affect access to or provision of services, or payment of services, is required. The MCO must make a good-faith effort to provide a minimum of 45 calendar days' advance notice of any necessary changes.

7. Provider-Patient Communication/Anti-Gag Clause

a. Subject to the limitations described in 42 CFR 438.102(a)(2), the MCO must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following:

i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

ii. Any information the member needs in order to decide among relevant treatment options.

iii. The risks, benefits, and consequences of treatment or non-treatment.

iv. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions.

b. Any MCO that violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1) will be subject to intermediate sanctions.

c. The MCO must comply with the provisions of 42 CFR 438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to physician incentive plans.

8. Provider Complaint System

a. A provider 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.

b. The MCO must establish a provider complaint system to track the receipt and resolution of provider complaints from in-network and out-of-network providers.

c. This system must be capable of identifying and tracking complaints received by telephone, in writing, or in person, on any issue that expresses dissatisfaction with a policy, procedure, or any other communication or action by the MCO.

d. As part of the provider complaint system, the MCO must:

i. Have dedicated provider services staff for providers to contact via telephone, electronic mail, regular mail, and in person, to ask questions, file a provider complaint, and resolve problems.

ii. Identify a key staff person specifically designated to receive and process provider complaints.

iii. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual, and provider subcontract provisions, collecting all pertinent facts from all parties and applying the MCO's and MTLC's written policies and procedures.

iv. Ensure that MCO executives with the authority to require corrective action are involved in the provider complaint escalation process. The names, telephone numbers, and email addresses of these individuals must be provided to MLTC within 15 calendar days of contract signing, and within two business days of any changes.

e. The MCO must prepare and implement written policies and procedures that describe its provider complaint system. These policies and procedures must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract's start date. The policies and procedures must include, at a minimum:

i. Allowing providers a minimum of 30 calendar days to file a written complaint, a description of the filing process, and the resolution timeframes.

ii. A description of how providers may file a complaint with the MCO for issues that are MCO-related, and under what circumstances they may file a complaint directly with MLTC for those issues that are not a MCO function.

iii. A description of how provider services staff are trained to distinguish between a provider complaint and a member grievance or appeal for which the provider is acting on the member's behalf.

iv. The process by which providers are allowed to consolidate complaints regarding multiple claims that involve the same or similar payment or coverage issues.

v. The process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation.

vi. A description of the methods used to ensure that MCO executive staff with the authority to require corrective action are involved in the complaint process, as necessary.

vii. A process for giving providers (or their representatives) the opportunity to present their cases in person.

viii. Identification of specific individuals who have authority to administer the provider complaint process.

ix. A description of the system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.

f. The MCO must include a description of the provider complaint system in its provider handbook and on its provider website. It must include specific instructions regarding how to contact the MCO's provider services staff and contact information for the MCO staff person who receives and processes provider complaints.

g. The MCO must distribute its policies and procedures to in-network providers at the time of contracting and to out-of-network providers with the remittance advice. The MCO may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the MCO's website. This summary must also detail how the in-network provider can request a hard copy from the MCO at no charge to the provider.

K. SUBCONTRACTING REQUIREMENTS

1. As required by 42 CFR 438.6(1), 438.230(a) and 438.230(b)(1), (2), and (3), the MCO is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

a. The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

b. The MCO must ensure that the prospective subcontractor is financially stable, according to the MCO's standards.

c. The MCO must have a written contract between the MCO and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

d. The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.

e. If necessary, the MCO must identify deficiencies or areas for improvement, and take corrective action.

2. The MCO must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of 90 calendar days prior to their planned implementation. MLTC must have the right to review and approve or disapprove all subcontracts entered into for the provision of any services under this RFP, including but not limited to, the MCO's PBM contract.

3. The MCO must not execute a subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. The MCO must not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

L. CARE MANAGEMENT

1. General Requirements

a. The MCO must develop a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators.

b. The MCO must work with its providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem. Principles that guide this care integration include:

i. The system of care must be accessible and comprehensive, and fully integrate an array of prevention and treatment services for all age groups. It must be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement.

ii. Mental illness and substance use disorder are health care issues that must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings.

iii. Many people suffer from both mental illness and substance use disorder. As care is provided, both illnesses must be understood, identified, and treated as primary conditions.

iv. Relevant clinical information must be accessible to both the primary care and behavioral health providers consistent with Federal and State laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

c. The MCO must assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition.

d. The MCO must incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. CM must engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate.

e. The MCO must identify members who require medium/intensive CM based on their chronic conditions. The MCO must identify and track members whose clinical conditions or social circumstances place them at a higher risk of eventually needing intensive CM services. The proactive engagement of and early intervention with at-risk members may prevent or minimize their eventual need for more intensive CM services.

f. The MCO's CM program must address the social determinants of health and how they may affect members' health and wellness. This requirement includes:

- **i.** Ensuring that all covered services, including mental health or substance use disorder treatment services, appropriate to a member's level of need, are available when and where the member needs them.
- **ii.** Ensuring that all care management staff are familiar with available community resources and will refer members to these resources, such as, but not limited to, housing assistance programs and shelters, food banks/pantries, educational opportunities, and organizations which can assist with and address physical and/or sexual abuse.
- **iii.** Developing, subscribing to, or acquiring a tool accessible to its care management staff that maintains updated information regarding these resources in Nebraska communities within 90 calendar days of the contract start date. The MCO shall make access to this information available to MLTC staff on request.

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

h. The MCO is required to provide CM separate from, but integrated with, utilization management (UM) and quality improvement (QI) activities. The major components of CM include advocacy, communication, problem-solving, collaboration, and empowerment.

i. As part of the CM system, the MCO must employ care coordinators and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to a member. See staffing requirements in Section IV.D Staffing Requirements.

j. A minimum of 60 calendar days prior to the contract start date, the MCO must provide to MLTC for review and approval a CM program description, policies and procedures, a description of services available at each CM level, member outreach procedures, and flow diagrams.

k. The MCOs must submit policies and procedures specific to care management for individuals who are dually eligible, have adult-onset disabilities, developmental disabilities and/or otherwise receive institutional or community-based long-term supports and services that address the unique needs of these populations.

l. In addition, the MCO must annually review, and update as necessary, with the input, review, and approval of the Clinical Advisory Committee (CAC), the CM policies and procedures. Once they are approved by the CAC, any proposed changes must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to intended implementation. All appropriate staff must be trained about the CM policies and procedures; they must also be shared with providers to promote consistency of care.

2. Health-Risk Screening/Assessment

a. The MCO must provide a health-risk screening to all members on enrollment to identify members in need of CM services.

b. As part of a health risk assessment, the MCO must use a variety of mechanisms to identify members potentially in need of CM services, including those who currently have or are likely to experience catastrophic or other high-cost or high-risk conditions. These mechanisms must include, at a minimum, evaluation of claims data, member self-referral, and physician referral. The MCO must submit the algorithms and methodologies it proposes to use to identify potential CM members to MLTC for review and approval a minimum of 60 calendar days prior to their intended implementation.

c. Health-risk assessments must be developed to collect information such as, but not limited to:

i. Severity of the member's conditions/disease state.

ii. Co-morbidities, or multiple complex health care conditions.

iii. Recent treatment history and current medications.

iv. Long-term services and supports the member currently receives.

v. Demographic and social information (including ethnicity, education, living situation/housing, legal status, employment status, food security).

vi. Activities of daily living (including bathing, dressing, toileting, mobility, and eating).

vii. Instrumental activities of daily living (including medication management, money management, meal preparation, shopping, telephone use, and transportation).

viii. Communication and cognition.

ix. Indirect supports.

x. General health and life goals.

xi. Safety (need for welfare/protection to eliminate harm to self or others).

xii. The member's current treatment providers and care plan, if applicable.

xiii. Behavioral health concerns, including depression, mental illness, suicide risk, and exposure to trauma.

xiv. Substance use, including alcohol.

xv. Interest in receiving CM services.

d. The MCO must assign members to risk stratification levels (low, medium, high), which determines the intensity of intervention levels and follow-up care required for each member. These member assignment levels and their criteria must also be provided to MLTC for review and approval a minimum of 60 calendar days prior to their intended implementation.

e. The MCO must ensure that members who have high costs or potentially high costs, or otherwise qualify, be assigned to the medium or high risk level and receive more intensive CM services.

f. The MCO must assign members with less intensive needs as low risk and provide access to basic CM services.

g. The MCO must conduct ongoing predictive modeling to identify members who may need CM evaluation.

3. Behavioral Health Principles of Care

a. The following behavioral health principles of care must guide the MCO's integrated service delivery system:

i. Services will be part of an overall coordinated system of care that ensures access to mental health (MH) and substance use disorder (SUD) treatment services to improve the overall health of every person served. To the fullest extent possible, services should be provided in the community where the member lives.

ii. Services will provide recovery-based care.

iii. Services will be trauma informed.

iv. Services will be person-centered, consumer and family driven, and age and developmentally appropriate.

v. Medicaid SUD services will be delivered in accordance with the principles of recovery-oriented systems of care.

vi. Members will be able to choose their own provider to the fullest extent possible at all levels of treatment.

vii. Services will provide a resiliency-based system of care for children and their families.

b. The MCO must ensure that "active treatment" is being provided to each member. Active treatment includes implementation of a professionally-developed and supervised individual plan of care, in which the member participates and shows progress.

4. Basic CM Services

a. The MCO must develop and adopt a CM program consistent with existing State policies and procedures to ensure all members who are eligible for CM have access to basic CM services.

b. The MCO's basic CM program must promote empowerment of the person and shared decision making. Examples of basic level CM services the MCO may provide include:

i. Assistance with appointment scheduling and identifying participating providers, when necessary.

ii. Assistance with CM and accessing primary care, behavioral health, preventive and specialty care, as needed.

iii. Coordination of discharge planning with a focus on the seriously mentally ill population.

iv. Coordination that links a member to providers, medical services, or residential, social, community, and other support services, when needed.

v. Continuity of care that includes collaboration and communication with other providers involved in a member's transition to another level of care, to optimize outcomes and resources while eliminating care fragmentation. Continuity of care activities must ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress, or problems. Continuity of care activities must provide processes by which MCO members and network/non-network provider interactions are effective and must identify and address those that are not.

vi. Assistance with identifying and referral to the social supports and community resources that may improve the health and living circumstances of a member, including but not limited to, nutrition, education, housing, legal aid, employment, and issues related to physical or sexual abuse.

vii. Following up with members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.

c. The MCO must develop and adopt policies and procedures annually (that have been approved in advance by MLTC) to address the following:

i. A strategy to ensure that all members and/or authorized family members or guardians are involved in care planning, as appropriate.

ii. A method to actively engage members in need of CM who are unresponsive to contact attempts or disengaged from CM.

iii. An approach that uses pharmacy utilization data to tailor CM services.

iv. An approach to encourage participation in CM activities by, and collaboration among, the following providers:

a) PCPs and behavioral health providers. This includes policies that ensure that PCPs refer members to behavioral health specialists when SMI is present or the member identifies as having a SMI.

b) HCBS service coordinators.

c) Community support providers.

v. Procedures and criteria for making referrals to specialists and sub-specialists to ensure that services can be furnished to members promptly and without compromising care. The MCO must (a) provide the coordination necessary for referral of MCO members to specialty providers to determine the need for services outside the MCO network and (b) refer a member to the appropriate service providers.

vi. Results of the identification and assessment of any member with SHCNs to ensure that services and activities are not duplicated and to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

vii. Procedures and criteria for maintaining care plans and referral services when a member changes PCPs.

viii. Documentation of referral services and medically indicated follow-up care in each member's medical record.

ix. Documentation in the member's medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.

x. A process that ensures that when a provider is no longer available through the MCO, the MCO allows members, who are undergoing an active course of treatment, to access services from non-contracted providers for an additional 90 calendar days to ensure continuity of care.

xi. A process that ensures continuity of care for members with SHCNs who are in CM.

d. For members assigned to medium risk care management, the MCO must meet basic care management requirement and:

i. Facilitate relapse prevention plans for members with depression and other high-risk behavioral health conditions and their PCPs (e.g., patient education, extra clinic visits, or follow-up telephone calls).

ii. Partner with provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence.

iii. Educate provider office staff about symptoms of exacerbation(s) and how to communicate with patients.

iv. Develop speaking points and triggers for making emergency appointments.

v. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors, or unmet needs.

e. For members assigned to high risk care management, the MCO must meet requirements for members assigned to low and medium risk care management and the MCO must develop and adopt policies and procedures (that have been approved in advance by MLTC) for the following:

i. As appropriate, organize the care using a person-centered, inter-disciplinary primary care and specialty treatment team to assist with development and implementation of individual medical care plans, that are in accordance with State QI and UM standards.

ii. Provide list of community resources (for referral).

iii. Plan for coordination and communication with State staff who are responsible for management of HCBS waivers.

iv. Develop a process to engage non-compliant members.

v. Develop a strategy for communication with members and their families, as well as key service and support providers and local social and community service agencies.

vi. Identify providers with special accommodations (e.g., sedation dentistry).

vii. Educate staff about barriers members may experience in making and keeping appointments.

viii. Facilitate group visits to encourage self-management of various physical and behavioral health conditions/diagnoses such as pregnancy, diabetes, or tobacco use.

ix. Communicate on a member-by-member basis on gaps/needs to ensure that a member obtains baseline and periodic medical evaluations from his/her PCP.

f. The MCO must develop, implement, and evaluate written policies and procedures consistent with existing State policies and procedures, regarding continuity of care. These written protocols must be reviewed on an annual basis by the MCO, be updated as needed, and provided to MLTC a minimum of 60 calendar days in advance of intended implementation for review and approval. In particular, the policies and procedures must address the following situations:

i. Members whose treating providers become unable to continue service delivery for any reason.

ii. Member transitions from the children's system to the adult system.

iii. Member transitions to/from IHS or other tribal agencies.

iv. Member discharges from inpatient and residential treatment levels of care, including State psychiatric hospitals.

5. Coordination with Providers and Other CM Programs

a. Members who are aged, blind, or disabled; dual eligible; or who are enrolled in HCBS waiver programs or other State programs are likely to have one or more case or care managers.

b. The MCO must demonstrate an understanding of health care and social service programs and initiatives offered by MLTC and other State agencies, and leverage those programs when appropriate for members receiving medium and intensive CM. Leveraging of existing programs may take the form of subcontracting or highly collaborative partnering, for example, and is intended to take advantage of existing resources and infrastructures to reduce or eliminate duplication of effort. Highly collaborative partnering must include, but is not limited to, crisis response services in coordination with behavioral health system entities.

c. The MCO must attempt to ascertain whether a member has any other case or care managers, and, if so, to engage with them. The MCO must also attempt to ascertain whether a member has

any other identified caregivers in the member's care planning and CM, and, if so, to engage with them.

d. The MCO is responsible for ensuring coordination between its providers and the WIC program. Coordination includes referral of potentially eligible women, infants, and children and providing appropriate medical information to the WIC program.

e. While the MCO must collaborate with other caregivers for overall planning and management, it retains responsibility for ensuring that the member continues to receive appropriate medical services in the most cost-effective manner.

f. The MCO must develop transition plans for persons discharging to the community from State psychiatric hospitals.

6. Special Considerations for Pregnant Members

a. The MCO must ensure that Medicaid members under its care who are pregnant begin receiving care within the first trimester, or within seven (7) days after enrolling in the MCO or notification of the member's pregnancy.

b. The MCO must provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services to its female members. A pregnant member must be assured direct access within the MCO's provider network to routine OB/GYN services, and the OB/GYN is required to notify the PCP of his/her provision of such care and coordinate that care with the PCP.

c. The MCO must develop an outreach program to encourage women to seek prenatal services during their first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include distribution of brochures and/or periodic articles that emphasize the importance of this care to all members.

d. The MCO must perform or require health providers to perform a risk assessment of all obstetrical patients including a screen for tobacco, alcohol, and substance use and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists. A pregnant woman is considered high-risk if one or more risk factors are indicated. The MCO must provide case management for high-risk obstetrical patients including, but not limited to, patients with a history of prior preterm birth.

e. The MCO must screen members for the DHHS Division of Behavioral Health Women's Set Aside program and make referrals to the Division of Behavioral Health (DBH) as appropriate. MLTC will provide screening criteria for the program.

f. The MCO must ensure that the PCP or the OB provides prenatal care in accordance with the guidelines of the American College of Obstetricians and Gynecologists. The MCO must ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child when the child is added to the MCO.

g. Appropriate referrals must also be made to the WIC program for nutritional assistance and other needed community resources. The MCO is responsible for ensuring that coordination occurs between the WIC program and MCO providers. Coordination includes referral of potentially eligible women, infants, and children and reporting appropriate medical information to the WIC program.

h. The MCO must develop and promote patient engagement tools including mobile applications and smartphone-based support to supplement existing pregnancy services. The MCO is required to provide details of its plan in the MCO Marketing Plan submitted to DHHS for approval. Some goals of this program are to:

i. Improve overall engagement in the maternity population and assist women with keeping appointments and educating them about needed health screenings throughout their pregnancy.

ii. Increase the appropriate identification and triage of high-risk pregnancies to evidence-based actions, including connection with maternity case managers or other public health resources.

i. Improve health decisions across the pregnant population based on available State-based and MCO-based programs and services.

j. The MCO must provide care management services to women postpartum who were identified as high risk during their pregnancy or who had an adverse pregnancy outcome, including preterm delivery within 37 weeks. Care management services shall include referral to safety net services for baby care and breastfeeding support.

7. Coordination with HCBS Service Coordinators

a. The MCO must collaborate and coordinate with HCBS case managers in a manner that complements, but does not duplicate, the member's plan of services and supports.

b. The MCO must develop and submit to MLTC for approval (a minimum of 60 calendar days in advance of intended implementation) a policy and procedures for coordination with HCBS case managers. This policy and these procedures must address methods the MCO will use to ensure that coordination services are not duplicated.

8. Coordination with Tribal Organizations

a. The MCO must develop policies for care coordination/collaboration for members who are Tribal members or are eligible for care through IHS or other Tribally-funded health and human services program, including:

i. Identification and appointment of a Tribal Liaison, to work with IHS and the Tribes.

ii. Development of processes and procedures to identify, ensure appropriate access to, and monitor the availability and provision of culturally appropriate care within the MCO's network.

iii. Development of processes and procedures to coordinate eligibility and service delivery with IHS, Tribally-operated facility/ program, and urban Indian clinics (I/T/Us) authorized to provide services pursuant to Public Law 93-638.

iv. Development of methods for regular planning to coordinate on a minimum of a quarterly basis with IHS, 638 providers, Urban Indian Centers, and other involved agencies to coordinate and facilitate health service delivery.

b. All policies and procedures must be submitted to MLTC for review and approvals a minimum of 60 calendar days prior to the contract start date and before new policies are to be implemented.

9. Coordination with the Division of Children and Family Services

The MCO must develop processes and procedures for collaboration with the Division of Children and Family Services for children who are in foster care placement. CM must include collaborating with the child's Children and Family Services Specialist and identifying and responding to a child's health care needs including behavioral health. Policies and procedures must include:

a. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

b. How health needs identified through screenings will be monitored and treated.

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

d. Steps to ensure continuity of health care services.

e. The oversight of prescription medications.

M. QUALITY MANAGEMENT

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

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

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

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

d. The MCO's QM program must include:

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

ii. Performance improvement projects (PIPs).

iii. Quality performance measurement and evaluation.

iv. Member and provider surveys.

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

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

2. Quality Management Deliverables

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

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

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

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

i. Data collection and analysis.

ii. Evaluation and reporting of findings.

iii. Implementation of improvement actions, where applicable.

iv. Individual accountability for each activity.

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

e. Specific types of problems requiring corrective action.

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

g. Procedures for provider review and feedback about results.

h. Annual QM evaluation that includes:

i. Description of completed and ongoing QM activities.

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

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

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

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

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

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

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

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

3. QAPI Program

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

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

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

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

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

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

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

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

4. QAPIC

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

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

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

i. The MCO's QM Coordinator.

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

iii. The MCO's Medical Management Coordinator.

iv. The MCO's Member Services Manager.

v. The MCO's Provider Services Manager.

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

vii. Adult Medicaid members.

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

d. The MCO's QAPIC must:

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

ii. Review the Cultural Competency Plan.

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

iv. Establish annual performance targets.

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

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

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

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

e. Additional required committees must include:

i. Clinical Advisory Committee.

ii. Corporate Compliance Committee.

iii. Provider Advisory Committee.

iv. Utilization Management Committee.

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

5. Data Collection

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

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

i. Verifying the accuracy and timeliness of reported data.

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

iii. Collecting service information using MLTC-developed templates.

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

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

6. Quality Performance Measurement and Evaluation

a. The MCO must report specific performance measures, as listed in Attachment 7 – Performance Measures. MLTC may update performance targets, including choosing additional performance measures or removing performance measures from the list of requirements, at any time during the contract period. Performance measures include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, CHIPRA Quality Measures required

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

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

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

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

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

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

7. Performance Improvement Projects

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

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

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

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

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

iii. A study population.

iv. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The MCO must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The MCO must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

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

vi. Implementation of system interventions to achieve quality improvement.

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

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

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

d. The MCO must submit to MLTC the status or results of its PIPs in its annual QM Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.

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

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

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

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

8. Member Satisfaction Surveys

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

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

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

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

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

9. Provider Satisfaction Surveys

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

b. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval a minimum of 90 calendar days prior to its intended administration. The methodology used by the

MCO must be based on proven survey techniques that ensure an adequate sample size and statistically valid and reliable data collection practices with a confidence interval of a minimum of 95% and scaling that results in a clear positive or negative finding (neutral response categories shall be avoided). The MCO must utilize measures that are based on current scientific knowledge and clinical experience.

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

10. MLTC Quality Management Committee

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

11. Member Advisory Committee

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

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

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

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

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

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

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

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

12. Clinical Advisory Committee

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

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

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

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

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

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

13. External Quality Review

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

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

N. UTILIZATION MANAGEMENT

1. General Requirements

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

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

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

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

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

2. UM Program Description

The MCO must have a written UM Program description that outlines its structure and accountability mechanisms. The description must be submitted to MLTC for written approval annually and include, at a minimum:

a. Criteria and procedures for the evaluation of medical necessity of medical services for members.

b. Criteria and procedures for pre-authorization and referral for covered services that include provider and member appeal mechanisms.

c. Mechanisms to detect and document over- and under-utilization of medical services.

d. Mechanisms to assess the quality and appropriateness of care furnished to members with SHCNs.

e. Availability of UM criteria to providers.

f. Involvement of actively practicing, board-certified physicians in the program to supervise all review decisions and review denials for medical appropriateness.

g. Availability of physician reviewers to discuss determinations by telephone with physicians who request them.

h. Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers.

i. A process and procedures to address disparities in health care.

j. A process for identifying and analyzing clinical issues by appropriate clinicians and, when necessary, developing corrective actions to improve services.

k. A description of the MCO's approach to service authorizations, concurrent UR, and retrospective UR. The MCO must submit this description to MLTC for approval no later than 60 calendar days prior to the contract start date, annually thereafter, and prior to any intended revisions. MLTC's approval must be obtained prior to implementation of these policies.

l. Reasonable steps to ensure that network providers prescribe pharmaceuticals in accordance with the policies and instructions provided by MLTC and reflected in the MLTC's Preferred Drug List and other State publications.

m. A process for providing prescribers with members' drug utilization data obtained from MLTC and the Nebraska DUR board to inform prescribing activity. As part of this effort, the MCO must:

i. Work to improve collaboration across prescribers, to reduce conflicting or duplicate prescribing.

ii. Provide reports to PCPs and other network providers about the patterns of prescription utilization by members, in an effort to increase collaboration and reduce inappropriate prescribing patterns.

n. A description of the MCO's annual evaluation of its UM program. This evaluation must be submitted to MLTC annually, no later than 30 calendar days after its completion.

3. Practice Guidelines

a. The MCO must develop practice guidelines, in accordance with 42 CFR 438.236(b), that:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

ii. Consider the needs of the MCO's members, including children with serious emotional disorders and adults with serious and persistent mental illness.

iii. Are adopted in consultation with participating health care professionals.

iv. Comply with State and Federal requirements.

v. Are approved in advance by the Clinical Advisory Committee and MLTC.

vi. Are reviewed and updated a minimum of annually, as appropriate.

vii. Are disseminated, by the MCO, to all affected providers and, on request, to members and enrollees (42 CFR 438.236(c).

viii. Are posted to the MCO's website.

ix. Provide a basis for consistent decisions for utilization management, member education, service coverage, and any other areas to which the guidelines apply (42 CFR 438.236(d).

b. The MCO must provide affected network providers with technical assistance and other resources to implement the practice guidelines.

c. The MCO must coordinate the development of clinical practice guidelines with other MLTC MCOs to avoid providers receiving conflicting guidelines from different MCOs.

d. The MCO must monitor the application of practice guidelines annually through peer review processes and collection of performance measures for review by the MCO's QAPIC.

e. Using information acquired through its QM and UM activities, the MCO must recommend to MLTC each year the implementation of practice guidelines, including compliance and outcomes measures and a process to integrate practice guidelines into care management and UR activities.

4. Service Authorization Procedures

a. The MCO and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. The MCO must have processes to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider, when appropriate.

b. The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a practitioner with the necessary credentials and experience, and who has appropriate clinical expertise in treating the member's condition or disease.

c. The MCO must develop service authorization procedures with the input, review, and approval of the Quality of Care Clinical Advisory Committee. These procedures must be submitted to MLTC, for review and approval, a minimum of 60 calendar days prior to the contract's start date.

d. The MCO must:

i. Incorporate the definition of medical necessity for covered services, inclusive of service definitions and levels of care, into MCO documents, where applicable.

ii. Not require service authorization for emergency services.

iii. Place appropriate limits on service delivery (applying criteria, such as clinical guidelines for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose.

iv. Not arbitrarily deny a required service solely because of the member's diagnosis, type of illness, or condition. This also applies to the MCO's subcontractors.

v. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

vi. Require general notification to participating providers of revisions to the formulary and pharmacy prior authorization requirements.

vii. Use a licensed child and adolescent psychiatrist to review prior authorization requests for psychotropic medication use in youth as described under Section IV.D Staffing Requirements of this RFP.

viii. Have written policies and procedures for prescribers to request peer review and peer-to-peer consultations on prior authorizations. Peer-to-peer review or peer consultation must be conducted by a State-licensed prescriber.

ix. Consult with the requesting network provider, when appropriate.

x. Notify the requesting provider, and give the member written notice, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404.

xi. For standard authorizations, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the member's health condition requires and within the timeframes included in Section IV.H Grievances and Appeals of this RFP.

xii. For expedited service authorizations, make a decision within the timeframes identified in Section IV.H Grievances and Appeals of this RFP, including when the network provider indicates, and the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, or would cause a prudent layperson, possessing an average knowledge of medicine and health, reason to believe that his/her condition is of such a nature that failure to obtain immediate medical care could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

5. Service Authorizations for Pharmacy Services

a. The MCO must submit to MLTC, for review and written approval a minimum of 60 calendar days prior to the contract's start date, clinical criteria for all drugs requiring clinical prior authorization, including:

i. Clinical criteria.

ii. Evaluation flow charts.

iii. Process supporting tables.

b. Prior authorization may be used for drugs under the following conditions:

i. When prescribing medically necessary non-formulary or non-preferred (non-PDL) drugs.

ii. When prescribing drugs inconsistent with approved FDA labeling, including behavioral health drugs; or when prescribing is inconsistent with nationally accepted guidelines.

iii. When prescribing brand name medications that have A-rated generic equivalents.

iv. To minimize potential drug over-utilization.

v. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

c. MLTC may, at its discretion, prohibit prior authorization for selected drug products or devices.

d. The MCO must maintain a toll-free telephone number and fax line for providers to submit requests for prior authorization of drugs that are non-preferred or subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests by phone or fax, and through an automated process. If the MCO or its pharmacy benefits manager operates a separate call center for prior authorization requests, it will be subject to the same provider call center standards set forth in Section IV.J Provider Services of this RFP.

e. The MCO may not penalize or charge the prescriber, pharmacy or enrollee in any way for authorization requests and approvals.

f. The MCO must allow submission of pharmacy prior authorization requests through a common written form within 30 calendar days of it being developed and approved by the Administrative Simplification Committee and MLTC.

g. A member receiving a prescription drug that is subject to new or different prior authorization requirements (e.g., new clinical edits, removal from formulary or PDL) shall be permitted to continue to receive that prescription drug if determined to be medically necessary for a minimum of another 60 calendar days. The MCO must determine whether this medical necessity is present in consultation with the prescriber.

h. The MCO is allowed to implement step therapy or fail first protocols to promote utilization of the most cost-effective and clinically appropriate drug therapy. However, if so implemented, the MCO must provide a clear process in writing for a provider to request an override of these restrictions. At a minimum, the MCO must grant the override when the prescriber provides evidence that the preferred treatment method has been or is likely to be ineffective in the treatment of the patient's medical condition or will cause or will likely cause an adverse reaction or other physical harm to the patient.

6. Concurrent Review

a. The MCO must develop a system of concurrent review for inpatient services to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one (1) day, based on the medical necessity determination.

b. An important feature of concurrent review is the evaluation of each hospital case against established criteria, including national clinical guidelines. The MCO must use published and commercially available criteria for hospital case reviews to facilitate evaluation by UR nurses.

7. Retrospective Utilization Review of Network Providers

a. The MCO must develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including:

i. A system to identify utilization patterns of all network providers by significant data elements and established outlier criteria for both inpatient and outpatient services.

ii. A reasonable appeal process that includes: standard communication with reasonable timelines, UR criteria that are clearly communicated and developed with provider and other stakeholder review and input, and opportunities for independent peer provider review of denied claims.

iii. Written policies and procedures through which the prescriber of pharmacy services is able to submit additional information for special consideration and additional review of denied prior authorization requests that do not meet criteria.

iv. Retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary, and were authorized and billed in accordance with the MCO's requirements.

v. Provider reviews related to Medicaid compliance issues.

vi. Procedures, based on best practices in the industry, which focus resources on individual and system outliers.

vii. Processes (based in part on clinical decision support, claims and outcome data, and medical record audits) for each provider that monitor and report under-and over-utilization of services at all levels of care, including monitoring providers' utilization of services by race, ethnicity, gender, and age.

viii. Processes for claims denied payment through retrospective review that ensure that claims are denied individually (i.e., that each claim denied must be specifically reviewed) and any denials (both those resulting in repayment and those withheld from a future payment) must be subjected to due process before payment is withheld or repaid. In the absence of a fully denied claim, the provider must be paid in good faith.

b. The MCO must monitor for potential off-label drug usage.

c. The MCO must monitor emergency services utilization by provider and member and have routine methods for addressing inappropriate utilization. For UR, the test for appropriateness of the request for emergency services must be whether a prudent layperson would have requested such services. For the purposes of this RFP, a prudent layperson is one who possesses an average knowledge of health and medicine.

d. These policies must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract start date or the policies' intended implementation. The policies must be reviewed by the MCO annually and updated as necessary.

8. Medication Therapy Management

a. The MCO must develop a medication therapy management (MTM) program specific to the needs of its members.

b. The MTM program shall include coordination among the MCO, the member, the pharmacist, and the prescriber using various means of communication and education. It must assist members in understanding their prescriptions and engage them in education about their medication and efforts to improve their compliance with prescribed medication regimens. It must also educate members about how to effectively communicate about their preferences and needs with their prescribers to promote shared decision-making.

c. At a minimum, the MTM program must assess prescribing patterns and treatment plans for psychotropic medications, medications at risk of abuse, and other medications identified by MLTC or the MCO.

d. The MCO must submit an annual report to MLTC that describes its MTM program activities, the relative effectiveness of its efforts over the reporting period, and the MCO's activities planned for the next reporting period.

9. Drug Utilization Review Program

a. The MCO must develop and maintain DUR programs, including prospective and retrospective DUR programs. The guidelines for these programs must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract's start date or intended implementation of any changes. The MCO must:

i. Establish and maintain retrospective DUR exception criteria.

ii. Conduct drug criteria analysis and generate and review member and provider profiles.

iii. Develop a case tracking system and project reports.

iv. Implement prescriber and pharmacy educational intervention program.

v. Conduct prescriber and pharmacy assessment/evaluation of educational intervention program.

vi. Submit an analysis of cost outcomes and an evaluation of the effectiveness of the prescriber and pharmacy educational interventions to members, prescribers, and pharmacies.

vii. Use results of reviews to inform MTM education and outreach needs.

viii. Perform, at a minimum, one (1) retrospective DUR intervention each quarter of the contract year.

ix. Submit quarterly to MLTC the documentation needed to support preparation of MLTC's annual CMS DUR report.

b. The MCO shall nominate a non-voting staff member to attend the Nebraska Drug Utilization Review Board meetings, which occur six (6) times a year, for the term of this contract. The MCO shall obtain MLTC's written approval of the nominee.

10. Psychotropic Drug Oversight

The MCO must:

a. Utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative. If appropriate, the MCO must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist.

b. Manage the prescribing of psychoactive medications to members age 20 and under by:

i. Measuring psychopharmacology usage and prescribing patterns.

ii. Monitoring the use of, and the claims related to, psychopharmacology to identify target populations (e.g., age subsets) for proposed interventions.

iii. Preparing member-specific profiles of medication use based on pharmacy data to inform MCO interventions with prescribers.

iv. Developing prescriber and pharmacy interventions that reduce unsupported atypical antipsychotic prescribing and prescribing of multiple medications to the same member. The MCO must:

a) Implement these interventions on the approval of MLTC.

b) Report to MLTC the results of the intervention.

c) Support MLTC pharmacy initiatives by promoting and communicating the adoption of clinical policy recommendations to PCPs, and other network providers, including behavioral health providers.

d) In consultation with the DUR board, propose to MLTC additional pharmacy interventions focused on members.

v. Submit reports to MLTC detailing approvals and denials of psychotropic medication requests for youth. The report must utilize the eligibility categories provided to the MCO via the enrollment files for each youth for whom a drug request is made by a prescriber. These reports must be submitted as specified in Attachment 6 – Reporting Requirements.

vi. If requested by MLTC, participate and collaborate with inter-agency workgroups and initiatives.

11. Restricted Services

a. The MCO is required, at a minimum, to implement a restriction program consistent with the provisions of 471 NAC 2 concerning restricted services, also known as restricted services procedures.

b. Restricted services are a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The restricted services mechanism cannot prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

c. MLTC may request that a member be placed in a restricted services status when it determines that over-utilization, duplication of services, non-compliance, or drug-seeking behavior is suspected of the member.

d. The MCO, through retrospective UR or through the recommendation of a network provider, may also determine that the services available to a member be restricted and communicate these restrictions to MLTC.

e. The MCO must:

i. Be able to implement in its claims system a restricted services status for a member and have the ability to communicate this status to MLTC and other MCOs.

ii. Provide enrollees and providers with advance written notification of the decision to restrict services provided to a member.

iii. Allow members in the restricted services program to change providers for cause.

iv. Conduct the following activities and have in place written policies and procedures, approved by MLTC, for such activities that fall under the care coordination and daily operational aspects of restricted services, including but not limited to:

a) Assigning a care manager to review, document, and manage the clinical or organizational needs of a member enrolled in restricted services.

b) Assigning staff member(s) to communicate and collaborate with MLTC's enrollment broker and Pharmacy Unit on an ongoing basis concerning the coordination and processes for restricted services.

c) Conducting retrospective UR to identify the potential need for restricted services for a member, in addition to requests by network providers for a review of utilization patterns by a member.

d) Maintaining sufficient documentation for all member restricted service recommendations, including but not limited to documentation of over-utilization or duplication of services and documentation from network providers who requested a review by the MCO of a member because of suspected over-utilization of services or duplication of services.

f. The continued need for restricted services for a member must be evaluated by the MCO a minimum of every two years.

g. If a member has a restricted services status and is unable to obtain care or services from his/her restricted services provider(s) due to extenuating services, the MCO must have policies and procedures in place to authorize necessary exceptions.

h. The MCO must submit a monthly report, in a manner and format to be specified by MLTC, of the status of all members participating in a restriction program.

12. Utilization Management Committee

a. The MCO must establish an internal UM Committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The UM Committee must be chaired or co-chaired by the Medical Director and must report its findings to the QAPIC. The UM Committee must review, at a minimum:

i. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan.

ii. Grievances and appeals (including expedited appeals and state fair hearings) related to UM activities to determine any needed policy changes.

iii. Information from UM operations relevant to system gaps are identified and shared with provider network staff through this committee.

iv. Results from internal audits of UM (e.g., live call monitoring and documentation reviews), to effect changes in policies and procedures and plan training activities.

O. PROGRAM INTEGRITY

1. General Requirements

a. The MCO must comply with all State and Federal laws and regulations relating to FWA in the Medicaid program, including but not limited to 42 CFR 438.1 – 438.812.

b. The Nebraska Medicaid Program Integrity Unit (NMPI) is the entity within MLTC charged with identifying and investigating allegations of FWA and erroneous payments.

c. The Medicaid Fraud and Patient Abuse Unit (MFPAU), of the Nebraska Attorney General's office, has primary responsibility to investigate and prosecute provider fraud for the Nebraska Medicaid program.

d. The MCO must certify that all statements, reports, and claims, financial and otherwise, are true, accurate, and complete. The MCO must not submit for payment purposes those claims, statements, or reports that it knows, or has reason to know, are not properly prepared or payable pursuant to Federal and State law, applicable regulations, its contract with MLTC, and MLTC policy.

e. The MCO must immediately report to NMPI any suspicion or knowledge of fraud including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent.

f. The MCO must pursue all recovery of payments identified as FWA or erroneous and reflect the recovery on the claim record. In the event that the MCO does not pursue all recoveries, including third-party liability (TPL), MLTC will pursue them and recoup the money.

g. In accordance with 42 CFR 433 and MLTC policies and procedures, the MCO must report overpayments made by MLTC to the MCO as well as overpayments made by the MCO to a provider or subcontractor.

h. The MCO, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR 455) about disclosure reporting. All tax-reporting provider entities that bill or receive Nebraska Medicaid funds as a result of this contract must submit routine disclosures in accordance with timeframes specified in 42 CFR 455(B), including at the time of initial contracting, contract renewal, within 45 calendar days of any change to the information on the disclosure form, a minimum of annually, and at any time on request.

i. The MCO must require that all its providers and subcontractors take all the necessary actions to permit the MCO to comply with the FWA and erroneous payments requirements included in this RFP, its contract with MLTC, and State and Federal regulations. To the extent that the MCO delegates oversight responsibilities to a third party, the MCO must require that the third party complies with all provisions of the contract relating to FWA and erroneous payments. Although all providers with whom the MCO contracts are enrolled in the Medicaid program and subject to its regulations, the MCO agrees to require, via contract, that those providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

j. The MCO must have a FWA and erroneous payments unit within the organization comprised of experienced staff members. As described in Section IV.D Staffing Requirements, this unit must include a State-based Program Integrity Officer and a minimum of one (1) investigator for every 50,000 or fewer members. The unit's primary purpose is to prevent, detect, investigate, and report suspected FWA and erroneous payments that may be committed by network providers, members, employees, or other third parties with whom/which the MCO contracts.

k. The MCO and its employees must cooperate fully with centralized oversight agencies responsible for FWA and erroneous payments detection and prosecution activities. This cooperation must

include providing access to all necessary case information, computer files, and appropriate staff. In addition, this cooperation may include participating in periodic FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members. The MCO must participate in the quarterly Nebraska Health Care Fraud Task force meeting by sending one of its dedicated FWA staff.

l. The MCO must cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. This cooperation must include providing, on request, information, access to records, and access to interview the MCO's employees and consultants, including but not limited to those with expertise in program administration, medical or pharmaceutical issues, or any other matter related to the investigation.

m. MLTC will not transfer its law enforcement functions to the MCO.

n. When NMPI requests access to or copies of any records or data maintained by the MCO or its providers, the response must be in the form and manner and by the due date requested by NMPI.

o. The MCO must confirm in writing, by completing a form that MLTC will provide during the readiness review and on an annual basis during the duration of the contract that the MCO's Compliance Officer(s) understand all requirements related to the MCO's receipt of State and Federal funds. The MCO must confirm that its officers understand that they are subject to criminal prosecution, civil action, or administration actions for any intentional false statements or other fraudulent conduct related to their contractual obligations.

p. NMPI will seek all appropriate remedies for fraud, abuse and violation of law if it determines that the MCO, a provider, employee, or subcontractor has committed fraud or abuse as defined in this contract, or has otherwise violated applicable law.

2. Policies and Procedures

a. The MCO must have policies and procedures that are designed to prevent, reduce, detect, correct, and report known or suspected FWA and erroneous payments in accordance with State and Federal requirements and its contract with the State. Requirements for these policies and procedures are described in this section.

b. All FWA and erroneous payment policies, and the designation of the compliance officer and committee must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date and a minimum of 30 calendar days prior to the intended implementation of any material changes. The MCO's submission of new or revised policies and procedures for review and approval by MLTC will not void any existing policies and procedures that have been approved by MLTC previously. Unless otherwise required by law, the MCO may continue to operate under existing policies and procedures until MLTC approves the new or revised policies for prospective application. The MCO must develop and use a certification process that demonstrates the policies and procedures were reviewed and approved by the MCO's senior management.

c. To remain in compliance with its contract with MLTC, the MCO must comply with current FWA and erroneous payments policies and procedures.

3. Prohibited Affiliations

a. In accordance with 42 CFR 438.610, a MCO may not knowingly have a relationship with and must have a proactive method to prevent the following relationship(s):

i. An individual or entity who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of:

a) A director, officer, or partner of the MCO.

b) A person with beneficial ownership of 5% or more of MCO equity.

c) A person or entity with an employment, consulting, or other arrangement with the MCO under its contract with the State.

iii. Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program.

iv. Any individual or entity listed on the Federal System for Award Management, the Office of Inspector General's List of Excluded Individuals and Entities database, or the Nebraska Medicaid Excluded Providers list.

b. The MCO must conduct a search of the then-current version of these lists monthly to capture exclusions and reinstatements that have occurred since the previous search.

c. When the MCO identifies a relationship with a debarred or excluded individual or entity, it must report it to NMPI within three (3) business days. The MCO must initiate efforts to sever the relationship with the debarred or excluded individual or entity immediately. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription.

d. If MLTC finds the MCO is not in compliance with these requirements, NMPI will notify the Federal DHHS Secretary of noncompliance and may not renew or otherwise extend the duration of the existing contract with the MCO unless the Secretary provides to the State and to the Congress a written statement describing the compelling reasons that support renewing the contract.

4. Excluded Providers

The MCO may not contract with or reimburse providers that are excluded by the Medicare, Medicaid, or Children's Health Insurance Programs (CHIP).

5. Federal Financial Participation

Federal financial participation (FFP) is not available for:

a. Funds paid to providers excluded by the Medicare, Medicaid, or CHIP. The MCO is responsible for the return of any money paid for services provided by an excluded provider.

b. Payments made to a provider or fiscal agent that fails to disclose ownership or control information.

c. Expenditures for services furnished by providers who/that fail to comply with a request made by the Federal DHHS Secretary or MLTC. As applicable, FFP will be denied for expenditures for services furnished beginning the day following the date the information was due to the Federal DHHS Secretary or MLTC and ending on the day before the date the information was supplied.

6. The MCO and MFPAU

a. The MCO and the MCO's subcontractors or providers, whether contracted or non-contracted, must make available to MFPAU, on request or as required by this contract, State or Federal law, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

b. The MCO must comply promptly with the MFPAU requests for data stored or formulated by the MCO or its subcontractors, including but not limited to, claims data, encounter data, eligibility information, and enrollment data, if MFPAU determines it is necessary to carry out its responsibilities.

c. When responding to a request for data, the MCO must certify that the data supplied to MFPAU is true, accurate, and complete. This data must be supplied without charge and in the form and time frames requested by MFPAU.

d. The MCO must allow MFPAU staff access to its location(s) of business, whether within or outside of the State. Access to the MCO's places of business must be allowed during normal business hours, and also at other times under special circumstances when after-hour admission is required. Special circumstances are at the sole discretion of MFPAU.

e. MFPAU has the right to recover inappropriately expended Medicaid funds directly from participating and non-participating providers, the MCO, its subcontractors, and any third party in the MCO network in criminally and civilly prosecuted cases or settlements. The MCO is not entitled to any part of recovered funds.

f. The MCO must subrogate to MFPAU any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products.

g. In the event that the MCO conducts a hearing or review of its decision to institute interventions or sanctions against a provider, MFPAU must be provided adequate notice of the hearing, and furnished copies, at that time, of any and all pleadings and evidence. MFPAU has the right to intervene in these proceedings. If necessary for MFPAU's investigative purposes, MFPAU may suspend these proceedings until MFPAU's investigation is complete.

h. Regardless of any monetary settlement, payment, intervention, sanction, or other agreement between the MCO and any provider suspected of fraud, MFPAU retains the right to pursue any and all appropriate civil or criminal actions against the provider.

7. National Provider Identifier

The MCO must require each of its contracted physicians to have a national provider identifier. This identifier must be included on the provider file submitted to the State.

8. Compliance Plan

a. The MCO must submit a written FWA and erroneous payments compliance plan to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date, and annually thereafter by December 31st of each year. The initial compliance plan must be approved by MLTC before it can be implemented. Requests for revision(s) to the plan must be submitted in writing to MLTC a minimum of 30 calendar days prior to the requested implementation date of the revision(s). MLTC will respond in writing with approval or questions within 15 calendar days. Revisions must be approved by MLTC prior to their implementation.

b. The FWA and erroneous payments compliance plan must include the following components:

i. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable State and Federal requirements.

ii. Agreement to report all allegations of fraud to the NMPI. The policies and procedures must designate those staff members responsible for reporting fraud.

iii. The designation of a Program Integrity Officer and compliance committee that is accountable to senior management and must ensure an adequately staffed compliance office.

iv. Discussion of the compensation and qualifications of the staff, who must be adequate in number and training, to effectively monitor the Nebraska Medicaid contract.

v. Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers, and subcontractors, enforced through well-publicized disciplinary guidelines.

vi. Effective training and education for the Program Integrity Officer, MCO employees, and subcontractors.

vii. Detailed information about the False Claims Act and the other provisions described in Section 1902(a)(68)(A) of the Social Security Act. A description of the methodology and standard operating procedures used to prevent, identify, intervene, and investigate FWA and erroneous payments, and to recover overpayments or otherwise sanction providers.

viii. Enforcement of standards through well-publicized guidelines included in member and provider handbooks, trainings, and member and provider newsletters.

ix. A description of the proactive specific controls in place to detect FWA and erroneous payments, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post-processing review of claims, and record reviews.

x. Provision that the MCO's FWA and erroneous payments unit has access to provider records.

xi. Procedures for ongoing monitoring and auditing of MCO systems, including but not limited to, claims processing, billing and financial operations, enrollment functions, member services, provider services, and continuous quality improvement; and the MCO's providers, subcontractors, employees, and any others, as appropriate.

xii. Procedures for timely, complete, and consistent exchange of information and collaboration with NMPI, MFPAU, and MLTC's contracted external quality review organization regarding suspected fraud and abuse.

xiii. Provisions for the confidential reporting of plan violations, such as a hotline to report violations, and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths must be created for the reporting of fraud so that such reports cannot be diverted by any supervisors or other personnel.

xiv. Protections to ensure that no individual who reports program integrity-related violations or suspected FWA is retaliated against by anyone who is employed by or contracts with the MCO. The MCO must ensure that the identity of individuals reporting violations or suspected violations of the compliance plan must be kept confidential to the extent possible. Anyone who thinks that s/he has been retaliated against may report this violation to MLTC or the Federal DHHS Office of Inspector General.

xv. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the contract in accordance with 42 CFR 438.608(b)(7).

xvi. Agreement to and the method the MCO will use to suspend all provider payments when notified by MLTC to suspend payments because of a credible allegation of fraud.

xvii. The method the MCO will use to comply with requests from NMPI or the MFPAU for access to and copies of any records kept by the MCO, computerized data stored by the MCO, or information maintained by MCO providers to which MLTC is authorized to have access.

xviii. The method the MCO will use to prevent payments to international accounts.

9. Employee Education

a. The MCO must comply with Federal law to educate employees about FWA, the compliance plan, and false claims recoveries (Deficit Reduction Act of 2005 – Section 6032). This includes:

i. Evidence of completed, effective education for the Program Integrity Officer and the organization's employees, MCO providers, and members about the compliance plan, FWA, and erroneous payments and how to report any allegations regarding any of them.

ii. Effective lines of communication between the compliance officer and the MCO employees, MCOs, providers, and MLTC and its designee(s).

iii. Established written policies for all employees (including management), and any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A) of the Social Security Act. The MCO must include detailed information about the MCO's policies and procedures for detecting and preventing FWA. The MCO must also include in any employee handbook a specific discussion of the laws described in the written policies, and the whistleblower rights and protections of and for employees.

b. This training must be conducted annually for all employees and within 30 calendar days of employment for new hires.

c. The MCO must require new employees to complete and attest to training within 30 calendar days of hire related to the following in accordance with State and Federal laws:

i. MCO code of conduct training.

ii. Privacy and security (including but not limited to HIPAA).

iii. FWA and erroneous payments.

iv. Procedures for the timely, consistent exchange of information and collaboration with MLTC.

v. Organizational chart, including the Program Integrity Officer and program integrity investigator(s).

vi. Provisions of 42 CFR 438.610 and all relevant State and Federal laws, regulations, policies, procedures and guidance (including CMS' *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks*) issued by MLTC, DHHS, CMS, the Office of Inspector General, including updates and amendments to these documents or any such standards established by the State.

d. The MCO must maintain a toll-free provider compliance hotline number and ensure that the number and an accompanying explanatory statement are distributed to its members and providers through its member and provider handbooks.

e. The MCO must create and disseminate written materials for educating employees, managers, providers, and subcontractors about health care fraud laws, the MCO's policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers. The MCO's education must comply with all requirements of Section 1902(a) (68) of the Social Security Act.

10. Service Verification

a. The MCO must have a method and regularly verify that services have been actually provided. This verification may be conducted by mail, electronic correspondence, or telephone. Sampling criteria may include a representative sample or a targeted sample. The MCO must report the results of this monitoring to NMPI quarterly.

b. The MCO must immediately notify NMPI of any providers who/that are excluded from the MCO network or that leave the network to avoid a for-cause termination.

11. Audit Requirements

a. Twice each year, the MCO must complete an error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The MCO must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a corrective action plan based on the audit results.

b. The MCO must also complete quarterly audits to identify:

i. Services paid after the recipient's death or incarceration.

ii. Home-based services, such as prescription drugs, therapies, or medical supplies, received by the patient while that patient is hospitalized, or living in or treated in a setting reimbursed at an all-inclusive rate.

12. Nebraska Medicaid Program Integrity Oversight

a. The MCO must notify NMPI if it identifies patterns of data mining outliers, audit concerns, critical incidences, hotline calls, or other internal and external tips with potential implications about provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15). This notification must be made on a minimum of a quarterly basis, unless circumstances warrant earlier notification. Along with such notification, the MCO must take steps to triage or substantiate these tips and provide timely updates to NMPI.

b. The MCO must report all tips and make all referrals to MLTC, in writing, a minimum of every two (2) weeks. The MCO must include all relevant documentation within this notification.

13. Monthly Reporting to MLTC

a. The MCO must submit the following reports to NMPI in the format, reporting period, and timeframe specified below. The MCO must also have documented policies and processes to collect the information necessary for the following reports:

i. A monthly cumulative report of all new referrals of potential FWA and erroneous payments received by the MCO. The report must be submitted electronically in an Excel spreadsheet that includes the following details: provider name, provider national provider identifier (NPI), Nebraska Medicaid Provider ID number, provider type, provider address, date the referral was received, a summary of the allegations, the previous calendar year's net payments to the provider, the current calendar years to-date net payments to the provider, the MCO staff person assigned to the referral, the source of the referral, the potential amount at risk, and a summary of investigative activities completed since receipt of the referral. The report is due by the second Friday of each month to report the previous month's information, if any.

ii. A monthly update of all previously reported referrals of provider FWA and erroneous payments under review by the MCO. The report must be sent electronically in an Excel spreadsheet and include the details from the new referrals report (described in the previous section) with updates to all investigative activities that have been completed since the receipt of the referral. This report is due by the second Friday of each month to report the previous month's information, if any.

iii.

iv. Monthly reports of claims adjudicated to finalization by the MCO in the previous calendar month. The report must include the number and dollar amount of claims submitted, the amount disallowed and reduced, the amount of payments by other sources, and net payments. This information must be reported by claim type, provider type, and the disallowed or reduced reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

v. A monthly report of all overpayments identified and collected. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

vi. A monthly report of all providers that have left the MCO provider network, including the provider's name, NPI, Medicaid Provider ID number, provider type, address, and reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

vii. A monthly report of the MCO's efforts to detect and prevent FWA. The report is due by the second Friday of each month to report the previous month's information, if any. The content of the report shall include, but is not limited to:

a) Utilization review activities.

b) Member and provider hotline complaints.

c) MCO QA/QI meeting minutes and reports.

d) All site-visit reports.

14. Collaboration with NMPI and Other MCOs

NMPI will hold regular meetings with all MCOs to review and discuss investigations, compliance, prevention, and other Program Integrity-related activities. These meetings will be attended by the MCO's Program Integrity Officer and CEO or COO. The MCO's Program Integrity Officer will serve as the primary point of contact for all issues related to FWA and erroneous payments.

15. Investigative Collaboration

a. The MCO must cooperate with all appropriate State and Federal agencies, including the MFPAU and the federal DHHS Office of Inspector General, in investigating fraud.

b. Once the MCO discovers potential fraud, it must promptly perform an investigation of all incidents of suspected or confirmed fraud that occurred in the ten years preceding the precipitating event. The MCO must promptly provide the results of any preliminary investigations to NMPI.

c. The MCO must not notify the provider of an investigation when there is a potential credible allegation of fraud.

d. The MCO must cooperate and assist MLTC and any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected FWA or erroneous payments. At any time during normal business hours, MLTC, MFPAU, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, federal DHHS, or any of their designees, and as often as they deem necessary during the contract period and for a period of six (6) years from the expiration date of the contract (including any contract extensions/renewals), have the right, power, and authority to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract or any other applicable laws.

e. The MCO and its subcontractors must make all program and financial records and service delivery sites open to the representative or any designees listed immediately above. MLTC, MFPAU, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above must have timely and reasonable access and have the right, power, and authority to examine and make copies, excerpts, or transcripts from any books, documents, papers, or records that are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcripts; contact and conduct private interviews with MCO clients, employees, and contractors; and complete on-site reviews of all matters relating to service delivery as specified by the contract. The rights of access in this subsection are not limited to the required retention period, but will last as long as records are retained. The MCO must provide originals or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and language requested.

f. The MCO's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

g. The MCO must notify NMPI when it denies a provider credentialing application, disenrolls a provider for program integrity-related reasons, or otherwise limits the ability of a provider to participate in the program, for program integrity reasons.

16. Payment Suspension Due to Credible Allegations of Fraud

a. The MCO must comply with federal laws and regulations (such as 42 CFR 455.23) that require the suspension of Medicaid payments when there is a credible allegation of fraud. NMPI will determine whether payments should be suspended or if an exception is appropriate. NMPI will notify the MCO of payment suspensions and the MCO must then suspend payments. The MCO must ensure that no Nebraska Medicaid dollars are received by a provider whose payments have been suspended or who/that has been terminated by MLTC.

b. In cases involving potential or confirmed risk to patients, NMPI and the MFPAU may allow the MCO to engage in actions that would otherwise be prohibited. Any prior approval will be provided to the MCO in writing, from NMPI and the MFPAU, and will detail the action or actions the MCO may take. The MCO may not take any action against the provider at issue that is not specified by NMPI and the MFPAU.

c. After a credible allegation of fraud, unless prior written approval is obtained from NMPI in coordination with the MFPAU, the MCO must not take any of the following actions:

i. Contact the subject of the investigation concerning any matter related to the investigation.

ii. Institute any interventions, sanctions, or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension, or termination.

iii. Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the provider.

iv. File any civil action based upon the suspected fraud against the subject of the investigation.

v. Enter into or attempt to negotiate any settlement or agreement regarding the suspected fraud.

vi. Accept any money or other thing of value offered by the subject of the investigation in connection with suspected fraud.

17. Recoupments

If the MCO thinks that it is appropriate to initiate a recoupment or withholding action against a provider under these circumstances, the MCO must consult with both NMPI and the MFPAU to ensure that such action is permissible. In the event that the MCO obtains funds from an action when recoupment or withholding is prohibited, the MCO must return the funds to the provider.

P. MCO REIMBURSEMENT

1. General Requirements

a. MLTC's contracts with MCOs for the HERITAGE HEALTH are full-risk arrangements, with the exception of a risk corridor as required and discussed in this section.

b. The State will make monthly capitation payments to the MCO to cover all services in the contract, except for any mother's costs of obstetrical deliveries, for which MLTC will pay the MCO a supplemental payment, in addition to the monthly capitation payment. Capitation payments will be made prospectively for prospective enrollment and retrospectively to the first day of the member's enrollment, and based on the MCO's electronic enrollment file.

c. The MCO must agree to accept, as payment in full, the capitation rate and supplemental payments established by MLTC pursuant to the contract, and must not seek additional payment from a member or MLTC for any unpaid cost.

d. The MCO must assume 100% liability for any expenditures above the monthly capitation rate.

e. Payment for items or services provided under this contract may not be made to any entity located outside of the United States. The term "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

f. The MCO must have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions must be borne by the MCO.

2. Capitation Rate Determination Process

a. MLTC will develop cost-effective and actuarially sound rates in accordance with generally accepted actuarial principles and CMS rules and regulations, appropriate for the populations covered and the services provided, as described in this RFP.

b. MLTC will not use a competitive bidding process to determine the MCO capitation rates.

c. Capitation rates will be in effect for the initial six (6) month contract period beginning with the program start date.

d. Monthly capitation rates have been established separately for two (2) regions, shown in the map in Attachment 9 – Rating Regions:

i. Rating Region One (1) consists of 41 counties: Antelope, Boone, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Gage, Hamilton, Jefferson, Johnson, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Pierce, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thurston, Washington, Wayne, and York.

ii. Rating Region Two (2) consists of 52 counties: Adams, Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Phelps, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, and Wheeler.

e. The categories of aid (COA) are:

i. Aged, Blind, and Disabled, ages birth to 20 years, males and females (ABD 00-20 M&F)

ii. Aged, Blind, and Disabled, ages 21 years and older, males and females (ABD 21+ M&F)

iii. Aged, Blind, and Disabled Duals, ages 21 and older, males and females (ABD 21+ Duals M&F)

iv. Aged, Blind, and Disabled, ages 21 years and older, women with cancer (ABD 21+ F-WWC)

v. Children's Health Insurance Program, males and females (CHIP M&F)

vi. Family under 1 year, M&F*

vii. Family 01-05 years, M&F

viii. Family 06-20 years, F

ix. Family 06-20 years, M

x. Family 21 years+, M&F

xi. Foster Care, M&F

xii. Katie Beckett 00-18 years, M&F

xiii. LTSS (Institutional) – Duals

xiv. LTSS (Institutional) – Non-Duals

xv. LTSS (Home and Community Based) – Duals

xvi. LTSS (Home and Community Based) – Non-Duals

*Family Category of Aid - Section 1931 Children and related and Section 1931 Adults and related populations.

Capitation rates are developed using encounter data, fee-for-service data, and supplementary financial information, from each MCO under contract at the time of this RFP's release, for the eligible populations from State fiscal years 2013, 2014, and 2015. Following is a list of adjustments considered in the rate development:

xvii. Utilization trend

xviii. Unit cost trend

xix. Medicaid program changes

xx. Coordinated care savings

xxi. MCO administrative allowance

f. Attachments 10-A – Physical and Behavioral, 10-B – Physical and Behavioral Health Databook, Rating Region 2, 10-C – Dual Databook and 10-D – Long Term Services and Supports Databook include databooks, provided by MLTC's actuary.

g. The MCO must provide any information requested by MLTC to assist in the determination of MCO rates. MLTC will give the MCO reasonable time to respond to the request, and the MCO must fully cooperate. MLTC will make the final determination as to what is considered reasonable.

h. A minimum of annually, MLTC and its actuary will jointly review the information necessary to develop actuarially-sound capitation rates. This review will include an analysis of any anticipated fee schedule changes or other programmatic changes to the HERITAGE HEALTH, claims experience cost reporting information collected from the MCO, Department of Insurance annual statements, various trend data sources, and administrative experience.

i. Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR 438.6(c). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

j. MLTC reserves the right to adjust the capitation rate more frequently than annually as program changes dictate. Circumstances precipitating a rate change include and are not limited to:

i. Changes to benefits and services included in the monthly capitation rates.

ii. Changes in Federal law, Federal regulations, State law, State regulations, State policies, or the Medicaid State Plan.

iii. Changes to Medicaid population groups eligible to enroll in HERITAGE HEALTH.

iv. Legislative appropriations and budgetary constraints.

k. MLTC's actuary will provide, as part of its certification of capitation rates, a narrative that identifies the specific data, assumptions, and methodologies behind the specific payment rates for each rating region. This narrative will address any MCO-specific factors that influence provision of

services to Medicaid members, including but not limited to, reserve contributions and capital costs.

3. Capitation Rates and Payment

a. MLTC will pay the MCO in accordance with the monthly capitation rates specified in Attachment 11 - Rates.

b. The monthly capitation payment is based on member enrollment for the month. This is determined by the total number of Medicaid members assigned to the MCO as of the last working day of the previous month. For age group assignment purposes, age is determined at the beginning of the month for which the payment is intended. The MCO will receive additional payments to cover the cost of services retroactive to the first day of the month of the member's enrollment.

c. The entire monthly capitation payment will be paid during the month of birth, the month of death, and the first month of any incarceration.

4. Transplant Services

The historical cost for transplant services is shown in Attachment 12 – Historical Transplant Cost Distribution Data. The cost for these historical transplants has been added to the base data so that the resulting capitation rates include the costs for these services. The MCO is encouraged to review the information in Attachment 12 – Historical Transplant Cost Distribution Data to assist in making a decision surrounding the appropriate level of reinsurance.

5. Supplemental Delivery Payments

a. In addition to the monthly capitation rate, MLTC will pay MCOs a one-time supplemental lump-sum payment for deliveries.

b. The MCO must pay for all covered services associated with maternity care of a pregnant member.

c. The supplemental delivery payment is intended to cover the care of the pregnant member, not the newborn.

d. When a member is enrolled in the MCO on her date of delivery and the delivery results in a live birth, MLTC will pay the MCO one supplemental maternity payment. The payment will not be prorated.

e. When a member is enrolled in the MCO for part of the pregnancy, but was not enrolled on the date of the delivery, the MCO will not receive the supplemental maternity payment, or any portion thereof.

f. For maternity cases that result in termination of the pregnancy or miscarriage, the MCO is reimbursed through the monthly capitation rate for the member. The MCO will not receive the supplemental delivery payment.

g. The supplemental payment for deliveries is intended to reimburse the MCO for five (5) months of prenatal care, the delivery, and two (2) months of post-partum care.

h. The supplemental payment is generated after documentation of a live birth. A live birth is defined as any birth not resulting in miscarriage, still birth, or any other birth not resulting in life.

i. The MCO must not bill for a supplemental maternity payment until the hospital inpatient delivery is paid by the MCO. The MCO must submit encounter data evidence of the delivery, plus any other inpatient and outpatient services for the maternity care of the member to be eligible to receive a supplemental delivery payment.

j. The MCO must request payment for the supplemental delivery payment no later than twelve months following the date of service for the delivery. Failure to have supporting records, when audited, may result in recoupment of the supplemental delivery payment.

6. Payment Adjustments

a. In the event an erroneous payment is made to the MCO, MLTC will reconcile the error by adjusting the MCO's next monthly capitation payment or future capitation payments on a schedule determined by MLTC.

b. Adjustments to prior capitation payments may occur if it is determined that a member's aid category or eligibility has changed.

c. In cases of a retroactive effective date for Medicare enrollment of a member, the MCO must recoup payments made to its providers. The MCO must initiate recoupments within 60 calendar days of the date the MCO becomes aware of Medicare enrollment. The MCO must instruct the provider to resubmit the claim(s) to Medicare.

d. The MCO must refund payments received from MLTC for a deceased member after the month of death and an incarcerated member the month after entering involuntary custody. MLTC will recoup the payment within 30 calendar days of the date MLTC notifies the MCO of death or incarceration. The MCO must notify MLTC should the MCO become aware of a member's death or incarceration.

7. Health Insurance Providers Fee

a. Pursuant to Section 26 CFR Part 47 (the applicable regulations providing guidance about section 9010 of the Affordable Care Act), the MCO must pay the Health Insurance Providers Fee (HIPF) annually. The full cost of the HIPF includes both the HIPF and the allowance for the federal income tax liability related to the HIPF.

b. MLTC will pay the portion of the HIPF specifically related to the MCO's performance of this contract, with an adjustment for federal and state income tax, as described below:

i. The MCO is required to submit Internal Revenue Service Form 8963, pursuant to the federal regulations referenced immediately above, to MLTC by September 5th of each year.

ii. All documents listed above and any additional data or information requested by MLTC must be submitted with an attestation by the reporting MCO in accordance with the certification requirements specified in Section IV.T Reporting and Deliverables.

iii. Following the determination of the amount to be reimbursed and the federal and state income tax impact related to the HIPF fee, the capitation rate per member per month for each aid category will be reprocessed. The capitation payment will include the prorated HIPF payment through December 31st. After January 1st, MLTC will determine a settlement, approved by MLTC's actuary, showing the amount already paid by the State for its portion of the HIPF tax. If the settlement calculation indicates MLTC owes the MCO, the amount due will be paid in a retroactive capitation payment.

iv. The MCO and MLTC's actuary will each calculate the HIPF, and compare the results. The MCO must provide MLTC with verification of payment to the IRS.

8. Risk Adjustment

a. Risk-adjusted rates will not be considered in the first year of this contract. For subsequent years of the contract, each MCO's proposed base capitation rates will be risk-adjusted based on the MCO's risk score, reflecting the expected health care expenditures associated with its enrolled members relative to the applicable total Medicaid population.

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

i. Each member will be assigned to risk categories based on his/her age, gender, and disease conditions. This information and the relative cost associated with each risk

category will reflect the anticipated utilization of health care services relative to the overall population.

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

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

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

9. Risk Corridor

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

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

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

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

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

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

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

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

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

10. MLTC Quality Performance Program

a. The MCO must participate in the MLTC quality performance program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes. Neb. Rev. Stat. 71-831 is provided as Attachment 13 – Neb. Rev. Stat. 71-831.

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

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

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

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

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

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

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

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

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

11. State Performance Penalties

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

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

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

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

12. Administrative Cap

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

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

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

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

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

13. Medical Loss Ratio

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

14. Reinvestment Accounts

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

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

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

b. Both the holding and reinvestment distribution accounts must:

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

ii. Have no risk-bearing investments.

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

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

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

e. The MCO must ensure that:

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

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

iii. Once the State has reimbursed the federal share, the MCO must accept the remaining State share for re-deposit into the reinvestment distribution account.

f. MLTC will ensure that:

i. The annual financial reporting package, including the MLR rebate calculation, risk corridor calculation, and earned/unearned hold-back calculation is reviewed, and written approval is provided, within 45 calendar days after receipt from the MCO.

ii. All funds deposited into the reinvestment holding account are transferred to the State by the MCO for reconciliation and reimbursement of the Federal share via reporting on CMS Form 64.

iii. The federal share of such dollars is determined and reimbursed to the federal government.

iv. The remaining State share is returned to the MCO for deposit into the reinvestment distribution account, which is managed by the MCO, subject to contractual requirements.

g. The MCO will be held responsible and accountable for the necessary fiduciary duties and functions required to administer the reinvestment holding and reinvestment distribution accounts. Oversight of the financial accounting will be in accordance with the financial management reporting requirements outlined in Section IV.T Reporting and Deliverables of this RFP.

15. Return of Funds

a. All amounts owed by the MCO to MLTC, as identified through routine or investigative reviews of records or audits conducted by MLTC or other State or Federal agencies, are due no later than 30 calendar days following MCO notification, unless otherwise authorized in writing by MLTC. MLTC reserves the right to collect amounts due by withholding and applying all balances due to MLTC from future payments. MLTC reserves the right to collect interest on unpaid balances beginning 30 calendar days from the date of initial notification. Any unpaid balances after the refund is due are subject to interest at the current Federal Reserve Board lending rate or an annualized rate of 10%, whichever is higher.

b. The MCO must reimburse MLTC for any federal disallowances or sanctions imposed on the State as a result of any failure by the MCO to abide by the terms of the contract. The MCO is subject to any additional conditions or restrictions placed on MLTC by the federal DHHS as a result of the disallowance. Instructions for the return of funds would be provided by written notice.

Q. PROVIDER REIMBURSEMENT

1. Reimbursement to In-Network Providers

The MCO must reimburse in-network providers for covered services provided to its members.

2. Provider Rate Increases

The MCO must ensure that any rate increases for providers of services under the State Medical Assistance Act required by legislative appropriation are passed on in their entirety to participating providers.

3. Enhanced Payments for Primary Care Services

In accordance with Section 1202 of the Affordable Care Act, the MCO must have mechanisms in place to reimburse providers for certain evaluation and management services and immunization administration services furnished by a physician with a specialty in family medicine, general internal medicine, or pediatric medicine. These services must be reimbursed at a rate not less than 100% of the Medicare payment rate for these services. The MCO must establish payment rates for these primary care services that are, at a minimum, consistent with the equivalent FFS Medicare rate.

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the MCO must:

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

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

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

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

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

5. Psychiatric Residential Treatment Facilities

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

6. Value-Based Contracting

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

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

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

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

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

7. Physician Incentive Plans

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

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

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

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

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

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

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

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

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

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

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

8. Payments to Out-of-Network Providers

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

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

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

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

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

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

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

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

additional reimbursements will be made to the MCO by MLTC for MCO members who elect to receive family planning services outside the MCO's provider network.

9. Reimbursement to FQHCs and RHCs

a. The MCO must reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34.

b. The MCO must not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

c. If a MCO is unable to contract with an FQHC or RHC within PCP access distance standards provided in Attachment 2 – Access Standards, the MCO is not required to reimburse that FQHC or RHC for out-of-network services without prior approval unless:

i. The medically necessary services are required to treat an emergency medical condition.

ii. FQHC/RHC services are not available through a minimum of one (1) MCO within MLTC's established travel standards.

d. The MCO may stipulate that reimbursement is contingent on receiving a clean claim and all medical information required to update the member's medical record.

e. The MCO must inform members of these rights in its member handbook.

10. Critical Access Hospital Contracting and Reimbursement

Per 471 NAC 10-010.03F and 10.010.06A, the MCO must make all critical access hospital (CAH) inpatient payments utilizing interim per-diem rates calculated by MLTC with an annual year-end cost settlement. The annual year-end cost settlement occurs at the end of each CAH's fiscal year. Outpatient rates are calculated by MLTC on a cost-to-charge basis with an annual year-end settlement. Critical access hospitals are listed in Attachment 16 – Critical Access Hospitals.

11. University of Nebraska Medical Center (UNMC) Physician/Practitioner Payments

In compliance with 471 NAC 18.006.02, the MCO must pass on supplemental payments for services provided by practitioners acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices, UNMC Physicians, and Nebraska Pediatric Practice, Inc. These payments are calculated into the capitation rate on a quarterly basis.

12. Provider-Preventable Conditions, Including Health Care Acquired Conditions

In accordance with Section 2702 of the Affordable Care Act, the MCO must have mechanisms in place to preclude payment to providers for provider-preventable conditions (PPCs) in compliance with 42 CFR 447.26(b). PPCs, including health care acquired conditions (HACs), are those conditions that occur in inpatient hospital settings. MLTC uses the full list of Medicare's HACs, with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients. To ensure member access to care, any reductions in payment to providers must be limited to the added cost resulting from the PPC. The MCO must require provider self-reporting through its claims systems, and track the PPC data and report it to the State via the encounter file. See Attachment 17 – 2015 Health Care Acquired Conditions for a listing of HACs that apply to this provision.

13. Effective Date of Payment for New Members

The MCO is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The MCO must reimburse a member, for payments already made by the member, for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a MCO will match the Medicaid eligibility date.

14. Inappropriate Payment Denials

If the MCO demonstrates a pattern of inappropriately denying or delaying provider payments for covered services, the MCO may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations in which MLTC has ordered payment after appeal but also to situations in which no appeal has been made (i.e., MLTC learns of the documented abuse from other sources.)

15. Payment for Emergency Services

In the event of a medical emergency, the MCO may pay a provider that is not enrolled with MLTC for medically necessary care provided to a member.

16. Pharmacy Reimbursement

a. The MCO's dispensing fee reimbursement must be, at a minimum, the current Medicaid FFS rate for independent pharmacies (defined as those with ownership of six (6) or fewer pharmacies), unless otherwise agreed between the MCO and the pharmacy provider.

b. The MCO and the PBM may not charge pharmacy providers transaction-based or claims-processing fees. The MCO may be subject to sanctions in the event it charges these fees. This applies not only to situations in which MLTC has investigated an appeal, but also to situations in which no appeal has been made (i.e., MLTC learns of the fee from other sources).

c. The MCO must calculate dispensing fees, administration fees, and any other fee payment amounts as approved by MLTC. The MCO must maintain in each paid claim record which methodology was used to determine final payment amounts, i.e. state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

17. Maximum Allowable Cost Program

a. The MCO must establish an extensive MAC program in order to promote cost containment when generics are utilized.

b. The MCO must provide a description of its MAC program for review and written approval by MLTC a minimum of 90 calendar days prior to the contract start date.

c. The MCO must establish a process for timely notification of the MAC pricing updates to network pharmacies. It must also provide this information on the MCO's website. The information must be reviewed and updated weekly.

d. Policies and procedures about MAC pricing must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

e. The MCO must eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace. MAC pricing must be reviewed and updated based on market changes a minimum of weekly for both price increases and decreases.

f. The MCO must have a process in place to ensure that MAC pricing is appropriate and not routinely below the wholesale price available to State pharmacists. The MCO must provide a reasonable administrative appeals process to allow a dispensing provider to contest a listed MAC rate, which includes the following requirements:

i. The MCO or its PBM must respond to a provider who has contested a MAC rate through this procedure within seven calendar days.

ii. The MCO or its PBM must take steps to determine if the MAC price is appropriate given current State market conditions.

iii. If an update is warranted, the MCO must make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

g. The MCO must provide a MAC file to the MLTC PDL contractor a minimum of quarterly. The file format will be defined by MLTC before the contract start date.

h. The MCO must override the MAC on PDL products when the name-brand product is preferred over the generic product.

i. The MCO must have a written policy and procedure that meets State and Federal requirements for providing brand-name products when the prescriber appropriately determines and documents that the brand-name product is medically necessary.

R. SYSTEMS AND TECHNICAL REQUIREMENTS

1. General Requirements

a. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, enrollment, care management, utilization, claims adjudication and payment, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. Reporting formats and other requirements will be determined by MLTC after contract award.

b. The MCO must provide documentation about its health information system that ensures data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data.

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

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c. The MCO must provide MLTC with live access to all its systems at any time.

2. HIPAA Standards and Code Sets

The MCO must be able to perform the following functions electronically including electronic claims management capabilities:

a. Receive enrollment verification via a HIPAA-compliant 834 format.

b. Receive electronic premium payments remittance advices via a HIPAA-compliant 820 format.

c. Provide enrollment verification in a HIPAA-compliant 270/271 format.

d. Accept prior authorization requests in a HIPAA-compliant 278 format.

e. Allow claims inquiry and response in a HIPAA-compliant 276/277 format.

f. Accept electronic claims transactions in a HIPAA-compliant 837 format.

g. Generate HIPAA-compliant electronic remittance advices in the 835 format.

h. Submit encounter data via the HIPAA-compliant 837 formats.

i. Make claims payments via EFT.

j. Transmit and receive the NCPDP transaction in the current HIPPA compliant format.

3. Resource Availability and Systems Changes

a. Resource Availability

i. The MCO must provide systems help desk (SHD) services for all MCO, MLTC and other State agency staff who may have direct access to MCO systems.

ii. The MCO's SHD must be available via local and toll-free telephone service and via e-mail from 7:00 am to 7:00 pm, central time, Monday through Friday. If requested by MLTC, the MCO must staff the SHD on a Saturday or Sunday.

iii. The MCO's SHD staff must be able to answer user questions regarding MCO system functions and capabilities; report any recurring programmatic and operational problems to appropriate MCO or MLTC staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate MLTC login account administrator.

iv. The MCO must ensure that individuals who place calls to the SHD between the hours of 7:00 pm to 7:00 am, central time, Monday through Friday, are able to leave a message. The SHD must respond to messages by noon of the following business day.

v. The MCO must ensure that recurring problems, not specific to system unavailability, identified by the SHD are documented and reported to MCO management within one business day of recognition so that deficiencies are promptly corrected.

vi. The MCO must have information systems (IS) service management system that provides an automated method to record, track, and report all questions or problems reported to the SHD.

b. Systems Policies and Procedures

i. The MCO must have in place written systems policies and procedures that document all manual and automated processes for its IS, including the safeguarding of all its information.

ii. The MCO must maintain and distribute to all users (including MLTC) distinct systems design and management manuals, user manuals, and quick reference guides.

iii. The MCO must ensure that the systems user manuals contain information about, and instructions for, using applicable systems functions and accessing applicable system data.

iv. The MCO must ensure that all manuals and reference guides are available in printed form and on the MCO's website.

v. The MCO must update the electronic version of these manuals immediately on taking effect, and make printed versions available within ten (10) business days of the update taking effect.

c. System Changes

i. The MCO's systems must conform to future federal and/or MLTC-specific standards for encounter data exchange a minimum of 90 calendar days prior to the standard's effective date, as directed by CMS or MLTC.

ii. If a system update or changes are necessary, the MCO must draft the appropriate revisions to the documentation, and forward them to MLTC for review and approval a minimum of 45 calendar days prior to intended implementation. Upon MLTC approval, the MCO must prepare revisions to the appropriate manuals before implementing the system changes, and must have printed manual revisions made within ten (10) business days of the system revision.

The MCO must notify MLTC of changes to its system a minimum of 90 calendar days prior to the projected date of the change. These changes include major upgrades, modifications, or updates to application or operating software associated with the following core production systems:

a) Claims processing.

b) Eligibility and enrollment processing.

c) Service authorization management.

d) Provider enrollment and data management.

e) Conversions of core transaction management systems.

iii. The MCO must respond to notification from MLTC of IS problems, excluding IS unavailability, in the following timeframes:

a) Within five (5) calendar days of notification from MLTC, the MCO must respond in writing regarding system problems.

b) Within 15 calendar days, the correction must be made or a requirements analysis and specifications document must be provided to MLTC.

c) The MCO must correct the deficiency by an effective date to be determined by MLTC.

d) The MCO's systems must have a system-inherent mechanism for recording any change to a software module or subsystem.

iv. Unless otherwise agreed to in advance by MLTC, the MCO must not schedule systems unavailability to perform system maintenance, repair, or upgrade activities to take place during hours that could compromise or prevent critical business operations.

v. The MCO must work with MLTC on any testing initiative required by MLTC and must provide sufficient system access to allow MLTC staff to participate in the testing activities.

4. Systems Refresh Plan

The MCO must provide to MLTC an annual systems refresh plan. This plan must outline how ISs within the MCO's span of control will be systematically assessed to determine the need to modify, upgrade, or replace application software, operating hardware and software, telecommunications capabilities, or information management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues. The systems refresh plan must also indicate how the MCO will ensure that the version and/or release level of all IS components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF to support the IS component.

5. Eligibility and Enrollment Data Exchange

The MCO must:

a. Receive, process, and update enrollment files sent daily by MLTC or the enrollment broker.

b. Update its eligibility and enrollment databases within 24 hours of receipt of these files.

c. Transmit to MLTC, in the formats and methods specified by MLTC, member address and telephone number changes.

d. Use the member's Medicaid ID number to identify each member across multiple populations and systems within its span of control.

e. Be able to identify potential duplicate records for a single member and, upon confirmation of this duplicate record by MLTC, resolve the duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged.

6. Other Electronic Data Exchange

a. The MCO's system must scan, house, and retain indexed electronic images of documents used by members and providers to interact with the MCO. These documents must be housed in appropriate database(s) and document management systems to maintain the logical relationships to certain key data such as member identification numbers, provider identification numbers, and claim identification numbers. The MCO must ensure that records associated with a common event, transaction, or member service issue have a common index that will facilitate the search, retrieval, and analysis of related activities, such as interactions with a particular member about a reported problem.

b. The MCO must implement optical character recognition technology that minimizes manual indexing and automates the retrieval of scanned documents.

7. Electronic Messaging

a. The MCO must provide a continuously available electronic mail communication link (email system) to facilitate communication with MLTC. This email system must be capable of attaching and sending documents created using software compatible with MLTC's installed version of Microsoft Office and any subsequent upgrades as adopted.

b. As needed, the MCO must be able to communicate with MLTC over a secure virtual private network (VPN).

c. The MCO must comply with national standards for submitting protected health information (PHI) electronically and must set up a secure email system that is password protected for both sending and receiving any PHI.

8. Provider Enrollment

On the effective date of the MCO contract and weekly thereafter, MLTC will furnish to the MCO a list of Nebraska Medicaid provider types and specialty codes. In order to coordinate provider enrollment records, the MCO must utilize these codes in all provider data communications with MLTC and the enrollment broker. The MCO will provide the following:

a. A weekly provider file to include provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information, and any other data as required by MLTC and in a format specified by MLTC.

b. All relevant provider ownership information as prescribed by MLTC, Federal, or State laws.

c. Performance of all Federal- or State-mandated exclusion background checks on providers (owners and managers). The providers must perform the same checks on all of their employees a minimum of annually.

d. Provider enrollment systems must include, at a minimum, the following functionality:

i. Audit trail and history of changes made to the provider file.

ii. Automated interfaces with all licensing and medical boards.

iii. Automated alerts when provider licenses are nearing expiration.

iv. Retention of NPI requirements.

v. System-generated letters to providers when their licenses are nearing expiration.

vi. Linkages of individual providers to groups.

vii. Credentialing information.

viii. Provider office hours.

ix. Provider languages spoken.

x. Provider disability accommodations.

9. Information Security and Access Management

a. The MCO's systems must utilize an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function must:

i. Restrict access to information on a "least privilege basis (e.g., users who are permitted inquiry privileges only will not be permitted to modify information).

ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities. Global access to all functions must be restricted to specified staff, with approval of MLTC.

iii. Restrict unsuccessful attempts to access system functions to three attempts, with a system function that automatically prevents further access attempts and records those occurrences.

b. The MCO must make system information available to duly authorized representatives of MLTC and other State or Federal agencies to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed.

c. The MCO's systems must contain controls to maintain information integrity. These controls must be in place at all appropriate points of processing. The controls must be tested in periodic and spot audits using a methodology to be developed jointly by MLTC and the MCO.

d. Audit trails must be incorporated into all systems to allow information about source data files and documents to be traced through the processing stages to the point at which the information is finally recorded. The audit trails must:

i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action.

ii. Have the date and identification "stamp" displayed on any online inquiry.

iii. Have the ability to trace data from the final place of recording back to its source data file or document.

iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs.

v. Facilitate auditing of individual records as well as batch audits.

vi. Be maintained online for no less than two (2) years and be retrievable within 48 hours.

e. The MCO's systems must have inherent functionality that prevents the alteration of finalized records.

f. The MCO must provide for the physical safeguarding of its data processing facilities and the systems and information housed within those facilities. The MCO must provide MLTC with access to data facilities on request. The physical security provisions must be in effect for the duration of this contract.

g. The MCO must restrict perimeter access to equipment sites, processing areas, and storage areas through a key card or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

h. The MCO must include physical security features designed to safeguard processor site(s) including fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

i. The MCO must put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside the MCO's span of control. This includes but is not limited to ensuring that no provider or member services applications can be directly accessible over the internet and must be appropriately isolated to ensure appropriate access.

j. The MCO must ensure that remote access users of its ISs can only access these systems through two-factor user authentication and by methods including VPN, which must be approved in writing and in advance by the State.

k. The MCO must comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the MCO must conduct a security risk assessment and communicate the results in an IS security plan provided prior to the start date of operations. This risk assessment must also be made available to appropriate Federal agencies.

10. Systems Availability, Performance, and Problem Management Requirements

a. The MCO must ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to confirmation of MCO enrollment (CME), electronic claims management (ECM), and self-service member and provider services functions are available to the applicable IS users at any time, except during periods of scheduled system unavailability agreed to by the State and the MCO. Unavailability caused by events outside of a MCO's control is outside the scope of this requirement.

b. The MCO must ensure that, at a minimum, all other system functions and information are available to the appropriate system users between the hours of 7:00 am and 7:00 pm, central time, Monday through Friday.

c. The MCO must ensure that the systems and processes within its span of control associated with its data exchanges with the State are available and operational according to specifications and the data exchange schedule.

d. In the event of a declared major failure or disaster, the MCO's eligibility/enrollment and claims processing systems must be back online within 72 hours of the failure or disaster.

e. On discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and information, as defined in this section of the contract, including any problems affecting scheduled exchanges of data between the MCO and the State, the MCO must notify MLTC within 60 minutes of such discovery. In its notification the MCO must explain in detail the impact to critical path processes, such as enrollment management and encounter submission processes.

f. When the problem results in delays in report distribution or problems with online access to critical systems functions and information during a business day, the MCO must notify MLTC within 15 minutes of discovery of the problem. This notification will allow the applicable work activities to be rescheduled or handled based on IS unavailability protocols.

g. The MCO must provide a minimum of hourly updates to MLTC on IS unavailability events, including problem resolution. At a minimum these updates must be provided via email or telephone.

h. The MCO must resolve unscheduled IS unavailability and restore services of CME and ECM functions, caused by a failure of systems and telecommunications technologies within the MCO's span of control, within 60 minutes of the official declaration of system unavailability. Unscheduled system unavailability to any other MCO IS functions caused by system and telecommunications technologies within the MCO's span of control must be resolved, and the restoration of services implemented, within eight hours of the official declaration of IS unavailability.

i. Cumulative system unavailability caused by systems or infrastructure technologies within the MCO's span of control must not exceed 12 hours during any continuous 20 business day period.

j. The MCO is not responsible for the availability and performance of systems and infrastructure technologies outside of its span of control.

k. Within five (5) business days of the occurrence of a system availability problem, the MCO must provide MLTC with full written documentation that includes a corrective action plan describing how the MCO will prevent the problem from occurring again.

11. Contingency Plan

a. The MCO, regardless of the architecture of its systems, must develop and be continually ready to implement, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made), to continue essential application or IS functions during or immediately following the failure or disaster.

b. Contingency plans must include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP must focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items, such as employee notification processes and the procurement of office space, equipment, and supplies needed to do business in emergency mode.

c. The MCO must submit a final contingency plan to MLTC for review and approval no later than 45 calendar days before the contract start date.

d. At a minimum, the contingency plan must address the following scenarios:

vi. The central computer installation and resident software are destroyed or damaged.

vii. System interruption or failures that result from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage.

viii. System interruption or failure that result from network, operating hardware, software, or operations errors that compromise the integrity of data maintained in a live or archival system.

ix. System interruption or failure that result from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but prevents access to the system, such as causing unscheduled system unavailability.

x. The plan must specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

xi. The MCO must annually test its plan through simulated disasters and lower level failures in order to demonstrate to MLTC that it can restore systems functions on a timely basis. In the event the MCO fails to demonstrate through these tests that it can restore systems functions, the MCO must submit a corrective action plan to MLTC describing how the failure will be resolved within ten business days of the conclusion of the test.

12. Off-site Storage and Remote Back-up

a. The MCO must provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

b. The data back-up policy and procedures must include, but not be limited to:

vi. Descriptions of the controls for back-up processing, including how frequently back-ups occur.

vii. Documented back-up procedures.

viii. The location of data that has been backed up (off-site or on-site, as applicable).

ix. Identification and description of what is being backed up as part of the back-up plan.

x. Any change in back-up procedures in relation to the MCO's technology changes.

c. MLTC must be provided with a list of all back-up files to be stored at remote locations and the frequency by which these files are updated.

13. Records Retention

a. The MCO must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Online access to claims processing data must be possible by Medicaid ID number, provider ID number, and/or internal control number). The MCO must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed.

b. The historical encounter data submission must be retained for a period not less than six (6) years, following generally accepted retention guidelines.

S. CLAIMS MANAGEMENT

1. General Requirements

The MCO must develop and maintain claims processes that ensure the correct collection and processing of claims, as well as analyzes, integrates, and reports data. These processes must result in information about service utilization, claims disputes, and appeals that can be used for process and program improvement.

2. Functionality

a. The MCO must maintain an electronic claims management (ECM) system that will:

i. Uniquely identify the attending and billing provider of each service.

ii. Identify the date of receipt of the claim (the date the MCO receives the claim as indicated by the date stamp on the claim).

iii. Identify real-time accurate history with dates of adjudication, results of each claim, such as paid, denied, pended, adjusted, voided, appealed, etc., and follow-up information about disputed claims.

iv. Identify the date of payment, (the date of the check or other form of payment), and the number of the check or EFT.

v. Identify all data elements as required by MLTC for encounter data submission, as described in this RFP.

vi. Have the ability to integrate member claim and diagnosis history for use when adjudicating claims to override edit checks (such as prior authorization), based on the existence of a diagnosis or prior claim history.

vii. Accept submission of paper-based claims and electronic claims by participating providers, and non-participating providers according to the MCO policies as approved by MLTC.

viii. Accept submission of electronic and paper adjustment and void transactions.

ix. Have the capability to pay claims at $0.00.

x. For the purpose of this section, identify means to capture, edit and retain.

b. The ECM capability must function in compliance with the systems and data management requirements specified in Section IV.R Systems and Technical Requirements of this RFP.

c. The MCO must have ECM capability that can handle online submission of individual claims as well as accept and process batches of claims submitted electronically, with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, etc.).

d. The MCO must support an automated clearinghouse mechanism that allows providers to request and receive EFTs for claims payment.

e. The MCO must support a CAQH/Committee on Operating Rules for Information Exchange compliant interface to the automated clearinghouse that allows providers to request and receive EFTs of claims payments.

f. The MCO's claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

g. The MCO must adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These must include, but are not limited to, HIPAA-based standards and federally-required safeguards, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19.

h. The MCO must include nationally-recognized methodologies to correctly pay claims, including but not limited to:

i. Medicaid Correct Coding Initiative for professional, ambulatory surgical center, and outpatient services.

ii. Multiple procedure/surgical reductions.

iii. Global day evaluation and management bundling standards.

i. The MCO must provide online and telephone-based capabilities to obtain claim processing status information.

j. The MCO must comply at all times with standardized paper billing forms/formats and all future updates.

k. The MCO must not employ off-system or gross adjustments when processing corrections for payment errors, unless the MCO requests and receives prior written approval from MLTC.

l. The MCO agrees that if MLTC presents recommendations concerning claims billing and processing that are consistent with industry norms, the MCO must comply with these recommendations within 90 calendar days.

m. The MCO must not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the MCO or a third party.

n. The MCO must assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the MCO, or due to systems within the MCO's span of control.

3. Claims Processing

a. Except for claims from pharmacy providers, the MCO must ensure that all provider claims are processed according to the following timeframes:

i. Within five (5) business days of receipt of a claim, the MCO must provide an initial screening and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

ii. Process and pay or deny, as appropriate, a minimum of 90% of all clean claims for medical services provided to members within 15 business days of the date of receipt. The date of receipt is the date the MCO receives the claim.

iii. Process and pay or deny, as appropriate, a minimum of 99% of all clean claims for medical services provided to members within 60 calendar days of the date of receipt.

iv. Fully adjudicate (pay or deny) all other claims within six (6) months of the date of receipt.

b. For pharmacy providers, the MCO must establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all clean claims from pharmacy providers for covered services are paid within seven calendar days of receipt and 99% of all clean claims are paid within 14 calendar days of receipt, except to the extent providers have agreed to an alternative payment schedule set forth in the provider contract. Any alternative payment schedules must be reported to MLTC within three business days of their implementation.

c. Rejected Claims

i. The MCO may reject claims because of missing or incomplete information. In those circumstances, the original claim must be returned to the provider accompanied by a rejection letter.

ii. A rejected claim should not appear on a remittance advice because it will not have been entered into the MCO's claims processing system.

iii. The rejection letter must indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. The letter must contain, at a minimum, the following information:

a) Member name and Medicaid ID number.

b) Provider ID number.

c) Date of service.

d) Total billed charges.

e) A list of known defects or reasons for rejection.

f) MCO's name.

g) The date the letter was generated.

d. Pended Claims

If a clean claim is received, but additional information is required for adjudication, the MCO may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

e. Adjustments and Voids

i. Incorrect claims payments must be adjusted or voided electronically.

ii. Only a paid claim may be adjusted or voided.

iii. Incorrect provider numbers or member Medicaid ID numbers cannot be adjusted. The claim must be voided and then resubmitted.

f. Timely Filing Guidelines

i. The MCO must not deny provider claims on the basis of untimely filing for claims that involve coordination of services or subrogation (when the provider is pursuing payment from a third party). In situations of third party benefits, the timeframes for filing a claim must begin on the date that the third party completes resolution of the claim.

ii. The MCO must not deny claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a provider files erroneously with another MCO but produces documentation verifying that the initial filing of the claim occurred timely, the MCO must process the provider's claim and not deny for failure to meet timely filing guidelines.

iii. For purposes of MCO reporting on payments to providers, an adjustment to a paid claim must not be counted as a claim and electronic claims must be treated as identical to paper claims.

g. Claim System Edits

i. The MCO must perform system edits, including but not limited to:

a) Confirming eligibility and MCO enrollment for each member.

b) Validating member name.

c) Validating unique member identification number.

d) Confirming benefit package variations.

e) Identifying invalid, missing, and/or mismatched NPIs and/or tax identification numbers that could result in improper payments.

f) Performing system edits for valid dates of service, including ensuring that the dates of services are not in the future or outside the member's Medicaid eligibility span.

g) Ensuring that timeliness standards are met.

h) Ensuring data accuracy.

i) Determining medical necessity, as defined by qualified, medically trained, and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

j) Determining whether a covered service requires prior authorization and if so, whether the MCO gave its approval.

k) Flagging, in an automated manner, a claim as being an actual or possible duplicate and either denying or pending the claim as necessary.

l) Ensuring that the service is covered and eligible for payment.

m) Ensuring that the system approves only those claims received from providers eligible to render services for which the claims were submitted and that the provider has not been excluded from receiving Medicaid payments.

n) Ensuring that the system evaluates claims for services provided to members to ensure that any applicable benefit limits are applied and that over-utilization standards are considered.

ii. The MCO must have the ability to update current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, Tenth Revision (ICD-10-CM), and other codes based on HIPAA standards and move to future versions as required.

iii. In addition to CPT, ICD-10-CM, ICD-10-PCS, and any other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the MCO's and MLTC's evaluation of performance measures.

iv. The MCO must perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with State and Federal requirements. This must include, as applicable, a review of provider documentation.

4. Drug Claims Processing

a. Use of a Pharmacy Benefits Manager

i. The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with the requirements of this RFP.

ii. The MCO must identify the proposed PBM and the ownership of the proposed PBM in its proposal. Before entering into a subcontract with a PBM, the MCO must obtain MLTC approval. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO must submit a written description of the assurances it would require and procedures it would put in place contractually, such as an independent audit, to prevent patient steering, ensure no conflicts of interest exist, and ensure the confidentiality of proprietary information. These assurances and procedures must be provided to MLTC for review and approval a minimum of 60 calendar days prior to the date pharmacy services begin under the contract.

iii. The MCO must submit a plan for oversight of the PBM's performance prior to the start of the MCO's PBM. The plan must be submitted a minimum of 60 calendar days prior to the PBM's intended contract start date for review and approval by MLTC. The PBM, if approved, must comply with this RFP and all MLTC requirements.

iv. The MCO must not allow its owned or contracted PBM to charge transaction fees to pharmacy network providers.

v. The MCO must oversee, monitor, and assist with the management of PBM activities, related to the use of mental health drugs for children, including the establishment of prior authorization criteria, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18. This includes ensuring the implementation of point of service (POS) system edits defined in the DHHS Psychotropic Drugs and Youth Initiative as outlined in Attachment 8 – PBM Claims Processing Edits for the Nebraska Medicaid Psychotropic Drugs and Youth Initiative.

b. The MCO must develop and implement a master set of pricing rules and algorithms that will be applied to all pharmacy claims based on business area, and State and Federal requirements and policies. These policies and procedures must be submitted to MLTC for review and approval a minimum of 90 calendar days prior to the contract start date.

c. The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any Nebraska Medicaid provider regardless of the prescriber's managed care network participation.

d. The claims processing system must edit and validate claim transaction submissions for completeness and accuracy in accordance with National Council for Prescription Drug Programs (NCPDP) standards. The system must have the ability to accommodate existing and future NCPDP standards, including, but not limited to, electronic and paper submission of multiple ingredient compound prescriptions, and partial fills.

e. The MCO claims processing system must, at a minimum, update its NDC file weekly, including all product, packaging, prescription, and pricing information and provide online access to reference file information.

f. The MCO's claims processing system must maintain a history of the pricing schedules and other significant reference data.

g. The MCO's drug claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

h. Provider Identifier

i. The MCO's claims processing system must use prescriber and pharmacy NPIs for claims processing. All prescribing participating providers must have an individual NPI number. This/these must be the same NPI number(s) used for enrollment in the Nebraska Medicaid program.

ii. The MCO must deny prescriptions written by prescribers who are not enrolled with Nebraska Medicaid.

i. Prospective Drug Utilization Review

i. The claims processing system must, at a minimum, establish a central electronic repository for capturing, storing, and updating prospective DUR data.

ii. The claims processing system must assess each active drug regimen of members in terms of ingredient duplication, therapeutic duplication, drug/drug interactions, drug/age contraindications, drug/gender limitations, drug/pregnancy contraindications, drug/disease contraindications, over- and under-utilization, incorrect dosage or duration of drug treatment, clinical abuse or misuse, and other clinically appropriate evaluations.

5. Payments to Providers

a. The MCO must have procedures, approved by MLTC, available to providers in written and electronic form for the acceptance of claim submissions that include:

i. The process for documenting the date of actual receipt of non-electronic claims and the date and time of electronic claims.

ii. The process for reviewing claims for accuracy and acceptability.

iii. The process for preventing the loss of claims.

iv. The process for reviewing claims to determine if they are complete, correct, and payable.

b. At a minimum, the MCO must run one (1) provider payment cycle weekly.

c. The MCO must encourage its providers, as an alternative to the filing of paper claims, to submit and receive claims information through electronic data interchange.

d. The MCO must notify all contracted providers to file claims associated with covered services directly to the MCO or its subcontractors (as applicable), on behalf of Nebraska Medicaid members.

e. The MCO must pay providers interest at an annualized rate of 12%, calculated daily for the full period in which a payable clean claim remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

6. Remittance Advice

a. The MCO must produce a remittance advice that reflects the MCO's payments or denials to providers. Each remittance advice generated by the MCO to a provider must clearly identify for each claim:

i. Name of the member.

ii. Unique member Medicaid identification number.

iii. Patient claim number or patient account number.

iv. Date of service.

v. Total provider charges.

vi. Member liability, specifying any coinsurance, deductible, copayment, or non-covered amount.

vii. Amount paid by the MCO and/or the amount denied and the HIPAA-compliant reasons for denial.

viii. An attachment to the RA if the claim was denied due to a TPL, including but not be limited to, TPL carrier information such as carrier code, policy number, and mailing address.

ix. A description of provider rights for claims disputes.

b. Adjustments and voids must appear on the RA under "Adjusted or Voided Claims" as either approved or denied.

c. The related remittance advice must be sent with the payment, unless the payment is made by EFT. Any remittance advice related to an EFT must be sent to the provider no later than the date of the EFT.

d. If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must specifically identify all the required information and documentation not submitted. Resubmission of a claim with the necessary information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

e. In compliance with 42 CFR 455.18 and 455.19, the following statement must be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable Federal and/or State laws."

7. Paid Claims Sampling

a. On a monthly basis, the MCO must conduct service verification surveys including providing members' own individual EOB notices or information to a sample group of members in a manner that complies with 42 CFR 455.20 and 433.116(e). In easily understood language, the required notice must specify:

i. The description of the service furnished.

ii. The name of the provider furnishing the service.

iii. The date on which the service was furnished.

iv. The amount of payment made for the service.

b. The MCO must stratify the sample group to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the MCO or MLTC considers a particular specialty

(or provider) to warrant closer scrutiny, the MCO may oversample this group. The paid claims sample should be a minimum of 2% of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 6 – Reporting Requirements.

c. The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

d. The MCO must track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to MLTC. The MCO must use the feedback received through this process to modify or enhance the verification of receipt of paid services sampling methodology.

e. Within three business days, results indicating that paid services may not have been received by the member, must be referred to MLTC and the MCO's fraud and abuse department for review.

f. The MCO must report the total number of service verification surveys sent out to members, the total number of surveys completed, the total number of services requested for validation, the number of services validated, and an analysis of interventions related to complaints or other issues, all according to the interval listed in Attachment 6 – Reporting Requirements.

8. Claims Dispute Management

a. The MCO must develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to MLTC for approval a minimum of 60 calendar days prior to the contract start date.

b. The claims dispute process must give providers the option to request binding arbitration for claims that have been denied, underpaid, or bundled, by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution. If the MCO and the provider are unable to agree on an association, the rules of the American Arbitration Association apply. The arbitrator must have experience and expertise in the health care field and must be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator must conduct a hearing and issue a final ruling within 90 calendar days of being selected, unless the MCO and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorneys' fees, must be shared equally by the parties. Each party shall bear its own attorneys' fees, if any.

c. The MCO must systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

d. The MCO must adjudicate each disputed claim to a paid or denied status within 30 business days of receipt.

9. Claims Payment Accuracy

a. On a monthly basis, the MCO must submit claims payment accuracy percentage reports to MLTC, in a format determined by MLTC.

b. The report must be based on an audit conducted by the MCO. The audit must be conducted by an entity or staff independent of claims management. Responsibilities and job requirements for the internal audit staff are outlined in Section IV.D Staffing Requirements of this RFP.

c. The audit must utilize a random sample of all processed or paid claims on initial submission in each month. A statistically-valid sample, with provider and financial stratification, must be selected from the entire population of electronic and paper claims processed or paid on initial submission.

d. The minimum attributes to be tested for each claim selected must include:

i. Claim data is correctly entered into the claims processing system.

ii. The claim is associated with the correct provider.

iii. Proper authorization was obtained for the service.

iv. Member eligibility on the processing date was correctly applied.

v. The allowed payment amount agrees with the contracted rate and the terms of the provider agreement between the MCO and the provider.

vi. Duplicate payment of the same claim did not occur.

vii. The denial reason, if applicable, was applied appropriately.

viii. Copayments were considered and applied if applicable.

ix. Patient liability was correctly identified and applied.

x. Modifier codes were correctly applied.

xi. Other insurance was properly considered and applied if present.

xii. Proper benefit limits were applied.

xiii. Proper coding including bundling and unbundling was applied.

e. The results of testing should be documented, at a minimum, to include:

i. Results of each attribute tested for each claim selected.

ii. The amount of any overpayment or underpayment for claims processed or paid in error.

iii. An explanation of the erroneous processing for each claim processed or paid in error.

iv. A determination of whether any error is the result of keying errors or errors in the configuration or table maintenance of the claims processing system.

v. Documentation that any claims processed or paid in error have been corrected.

f. If the MCO subcontracts for the provision of any covered services and the subcontractor is responsible for processing claims, the MCO must submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report must be based on an audit conducted in compliance with the requirements of this section of the RFP.

10. Encounter Data

a. The MCO must submit encounter data that meets established MLTC data quality standards. These standards are defined by MLTC to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. MLTC will revise and amend these standards as necessary to ensure continuous quality improvement.

b. The MCO must submit encounter data accurately, meeting the standard of 95% correct encounters. The MCO must make an adjustment to encounter claims when the MCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed.

c. The MCO must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The MCO must comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

d. In the event that the MCO denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO must submit all available claims data to MLTC without alteration or omission.

e. When the MCO has entered into capitated reimbursement arrangements with providers, the MCO must require submission of all utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of FFS claims. The MCO must require this submission from providers as a condition of the capitation payment and must make every effort to enforce this contractual provision to ensure timely receipt of complete and accurate data.

f. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by MLTC, in order to support comprehensive financial reporting and utilization analysis.

g. The MCO must submit encounter data according to standards and formats as defined by MLTC, complying with standard code sets and maintaining integrity with all reference data sources, including provider and member data.

h. All encounter data submissions are subject to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted, must be completed within one business day of receipt.

i. MLTC will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by MLTC, to ensure accurate processing or encounter data quality, and will return these transactions to the MCO for research and resolution. MLTC will require expeditious action on the part of the MCO to resolve errors or problems associated with these claims or the adjudication of these claims, including any necessary changes or corrections to any systems, processes, or data transmission formats. Generally the MCO must, unless otherwise directed by MLTC, address 90% of reported errors within 30 calendar days and address 99% of reported errors within 60 calendar days. These errors will be considered acceptably addressed when the MCO has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

j. MLTC may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan as required, may result in damages and sanctions as described in Section IV.V Contract Non-Compliance.

k. The MCO must collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data system, per the State's specifications.

l. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by the State, to support comprehensive financial reporting and utilization analysis.

m. The MCO must adhere to applicable Federal and MLTC payment rules in the definition and treatment of certain data elements, such as units of service.

n. The NPI is required on all claims and encounter submissions from providers who are eligible for an NPI. The MCO must assist providers to obtain an NPI, if necessary.

o. The MCO must ensure that encounter files contain settled claims, adjustments, denials, and voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom/which the MCO has a capitation arrangement. The MCO must ensure that the level of detail associated with encounters from providers with whom/which the MCO has a capitation arrangement must be equivalent to the level of detail associated with encounters for which the MCO receives and settles as a FFS claim.

p. The MCO CEO, CFO, or their designee must attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

q. All institutional and professional encounters must be submitted electronically in the standard HIPAA transaction formats, specifically the American National Standards Institute X12N 837. Compliance with all applicable Federal (including but not limited to HIPAA) and State requirements, as amended, is required. MLTC and the MCOs will coordinate the timing of the transition to future HIPAA standard transaction formats, as appropriate.

r. Initially, pharmacy encounter claims must be submitted in the State's current proprietary format. In the future, the MCOs are expected to move to the standard NCPDP transaction format. MLTC and the MCOs will coordinate the timing of the transition to the NCPDP transaction format. Compliance with Federal and State requirements, as amended, is required.

s. The MCO must have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, for submission into the appropriate HIPAA compliant formats.

t. Encounter records must be submitted so that payment for discrete services that may have been submitted in a single claim can be ascertained.

u. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all clean claims adjudicated and/or adjusted by the MCO.

v. Within two (2) business days of the end of a payment cycle, the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

w. The MCO must submit a weekly claim-level detail file of pharmacy encounters to MLTC that includes individual claim level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to, the total number of metric units; dosage form, strength, and package size; and NDC for each covered outpatient drug dispensed to Medicaid enrollees.

x. The MCO must institute processes to ensure the validity and completeness of the data it submits to MLTC. At its sole discretion, the State will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid ID number), category and sub-category (if applicable) of service, diagnoses codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals will also be reviewed and verified. Additionally, the MCO must reconcile all encounter data submitted to the State to control totals and to the MCO's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 6 – Reporting Requirements.

11. Drug Rebates

a. Nebraska Medicaid is required to and submits the following claims for rebate per Section 1927 of the Social Security Act:

i. Outpatient pharmacy drugs.

ii. Outpatient hospital drugs.

iii. Provider-administered drugs.

b. Section 1903(m)(2)(A) of the Social Security Act states that any outpatient drugs provided by MCOs are eligible for the rebates authorized under Section 1927 of the Act.

c. The MCO must incorporate the following requirements into its appropriate day-to-day systems and business activities:

i. Include the NDC and the date of payment for all encounter data for provider-administered drugs.

ii. Ensure that the NDC is appropriate for the HCPCS/CPT code based on the drug description, strength, and date of service.

iii. Ensure that the HCPCS/CPT and NDC units reported represent a medically appropriate dosing.

iv. Ensure that the date of service of the claim is not past the CMS-determined termination date of the drug.

v. Ensure the NDC is from a rebate-eligible manufacturer on the date of service of the claim.

d. The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies at the claims level for products purchased through the 340B discount drug program, and must have a system in place to transmit these files to MLTC's proprietary system. The MCO must utilize the NCPDP field designated for this purpose, or may include the 340B instructions in its Provider Handbook.

e. The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply to the MCO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. MLTC has the right to audit this information at any time. MLTC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that the information is confidential under applicable law.

f. The MCO is not authorized to negotiate rebates with drug companies for PDL products. MLTC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including drugs administered by medical professionals, must be exempt from these agreements.

g. The MCO must implement a process to timely support MLTC's Medicaid rebate dispute resolution processes. The MCO must assign a single point of contact to research any encounters that are denied on submission to MLTC or identified as a dispute by the manufacturer within 30 calendar days. The MCO must provide an explanation of these disputes to MLTC at the encounter level in a spreadsheet. If claim information is found to be in error, the encounter must be voided within five (5) business days of the determination.

h. The MCO must submit all drug encounters, including retail pharmacy prescription encounters and medical claim encounters for drugs administered by medical professionals, with the exception of inpatient hospital drug encounters, to MLTC. MLTC or its vendor will submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the MLTC Director pursuant to Section 2501 of the ACA.

12. Disputed Drug Encounter Submissions

a. At a minimum, on quarterly basis, MLTC will review the MCO's drug encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process, if any.

b. Within 60 calendar days of receipt of a disputed encounter file from MLTC, the MCO must, if needed, correct and resubmit any disputed encounters and send a response file that includes (1) corrected and resubmitted encounters, or (2) a detailed explanation of why the disputed encounters could not be corrected, including documentation of all attempts to correct the disputed encounters at an encounter claim level.

c. In addition to the administrative sanctions in Section IV.V Contract Non-Compliance, failure by the MCO to submit weekly drug encounter claims files and/or a response file to the disputed encounters file within 60 calendar days as detailed immediately above may result in a quarterly offset to the MCO's capitation payment. This offset will equal the value of the rebate assessed for the disputed encounters.

13. Audit Requirements

a. The MCO must ensure that its systems facilitate the auditing of individual claims. Adequate audit trails must be provided throughout the systems. To facilitate claims auditing, the MCO must ensure that the systems follow, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

b. State Audits

i. The MCO must provide to any State auditor (including the Auditor of Public Accounts), or his/her designee, on written request, files for any specified accounting period for which a valid contract exists, in a file format or audit-defined media required by the auditor. The MCO must provide information necessary to assist the auditor in processing or using the files.

ii. If the auditor's findings point to discrepancies or errors, the MCO must provide a written corrective action plan to MLTC within ten (10) business days of receipt of the audit report.

c. Audit Coordination and Claims Reviews

i. The MCO must coordinate audits with MLTC or its designee and respond within 30 calendar days of a request by MLTC regarding the MCO's review of a specific provider and/or claim(s), and the issue reviewed.

ii. In the event MLTC or its designee identifies a mispayment, the MCO has 30 calendar days from the date of notification of the mispayment to determine if the claim(s) were corrected or adjusted prior to the date of MLTC notification. On receipt of this notification, the MCO must not correct the claims, unless directed to do so by MLTC.

iii. MLTC reserves the right to review any claim paid by the MCO or its designee. The MCO has the right to collect or recoup any overpayments identified by the MCO from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the MCO will collect and remit the overpayment to MLTC. In the event the MCO does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the MCO must refund the overpayment to MLTC. Failure by the MCO to collect an overpayment from a provider does not relieve the MCO from remitting the identified overpayment to MLTC.

d. If the MCO performs pharmacy services audits, it must submit to MLTC the policies and procedures of this process for review and written approval. The MCO must not utilize contingency-fee-based pharmacy audits.

14. Claims Processing Reports

a. The MCO will report to MLTC, on a monthly basis, summary data on claims payment activity and reasons for claims denials. The reporting requirements will be provided by MLTC.

b. In concert with its claims payment cycle, the MCO must provide an electronic status report indicating the disposition of every adjudicated and adjusted claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the MCO. The status report must contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to, TPL data.

15. Third-Party Liability

a. General TPL Information

i. Pursuant to applicable law, the Medicaid program is the payer of last resort. All other available TPL resources must meet their legal obligation to pay claims before the MCO pays for the care of a Medicaid member.

ii. The MCO must exercise full assignment rights as applicable; must make every reasonable effort to determine any TPL to pay for services rendered to members under this contract; and, cost avoid or recover this liability from the third party(ies).

iii. At the request of MLTC, the MCO must demonstrate that reasonable effort has been made to seek, collect, and report TPL, and the MCO's cost avoidance and recovery efforts.

iv. MLTC has the sole responsibility for determining whether or not reasonable efforts have been demonstrated. This determination will consider reasonable industry standards and practices.

v. The MCO must coordinate benefits in accordance with 42 CFR 433.135, et seq., and 471 NAC 3-004 in order to avoid costs and recover payments from liable parties as appropriate. The term "state" means "MCO" for purposes of complying with the Federal regulations referenced in the immediately preceding sentence. However, the MCO must pay and chase claims for which third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.

vi. The MCO may utilize subcontractors to comply with coordination-of-benefit efforts for services provided under this contract. The two methods for coordinating benefits are cost avoidance and post-payment recovery.

vii. TPL is established when the MCO receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member.

viii. If the probable existence of TPL cannot be established, the MCO must adjudicate the claim. The MCO must recover payments if TPL is later determined to exist.

ix. The MCO must identify the existence of potential TPL to pay for covered services through the use of diagnosis and trauma code editing in accordance with 42 CFR 433.138(e).

x. If a TPL insurer requires the member to pay any co-payments, coinsurance, or deductibles, the MCO is responsible for making these payments even if the services are provided outside of the MCO network.

xi. The MCO, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party(ies), except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

xii. MLTC may require a MLTC-contracted TPL vendor to review paid claims that are over 90 calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the MCO's encounter data.

xiii. MLTC is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

b. Cost Avoidance

i. The MCO must cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

ii. The MCO may "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement for any liable TPL if:

a) The claim is for labor and delivery and postpartum care; however, any cost associated with the inpatient hospital stay for labor and delivery and post-partum care must be cost-avoided.

b) The claim is for prenatal care for pregnant women, or preventive pediatric services (including EPSDT).

c) The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D child support agency. The MCO must seek recovery of reimbursement within 60 calendar days after the end of the month in which the payment was made.

c. Post-Payment Recovery

i. Post-payment recovery is necessary in cases in which the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid.

ii. The MCO must seek recovery within 60 calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid.

iii. The MCO must have established procedures for recovering post-payments for MLTC's review and approval during the readiness review.

iv. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters.

v. The MCO must seek reimbursement in accident/trauma-related cases when claims in the aggregate equal or exceed $250, as required by the Medicaid State Plan.

vi. The amount of any recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

d. Distribution of TPL Recoveries

i. The MCO may retain up to 100% of its TPL collections if all of the following conditions exist:

a) Total collections received do not exceed the total amount of the MCO financial liability for the member.

b) There are no payments made by MLTC related to FFS claims, reinsurance, or administrative costs (i.e., lien filing, etc.).

c) Such recovery is not prohibited by applicable law.

ii. MLTC will utilize TPL data in calculating future capitation rates.

e. TPL Reporting Requirements

i. The MCO must provide TPL information to MLTC weekly in a format required by MLTC and must cooperate in any manner necessary with MLTC or its cost recovery vendor.

ii. Any money recovered from third parties will be retained by the MCO and reported monthly to MLTC.

iii. The MCO must post all third-party payments to claim level detail by member. The MCO must include the collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments.

iv. At the request of MLTC, the MCO must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. This information must be provided within 30 calendar days of MLTC's request. This information may include, but is not limited to, individual medical records to determine liability for the services rendered.

v. The MCO must report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in a format and medium specified by MLTC.

vi. The MCO must submit an annual report of all health insurance collections for its members plus copies of any Form 1099s received from insurance companies for that period of time.

f. Right to Conduct Identification and Pursuit of TPL

i. MLTC may pursue recovery if the MCO fails to recover reimbursement from the third party, to the limit of legal liability, 365 days from the date of service of the claim(s).

ii. The MCO must seek subrogation amounts regardless of the amount believed to be available as required by Federal law. The amount of any subrogation recoveries collected by the MCO outside of the claims processing system must be treated by the MCO as offsets to medical expenses for the purposes of reporting.

16. Coordination of Benefits Data

a. MLTC or its designee will provide the MCO with a list of known third party resources for its members via the enrollment file, based on information made available to MLTC at the time of eligibility determination or re-determination. If the MCO operates or administers any non-Medicaid HMO, health plan, or other lines of business, the MCO must assist MLTC with the identification of members with access to other insurance.

b. The MCO must provide, to MLTC, any third party resource information, in a format requested by MLTC, and must cooperate with MLTC or its cost-recovery vendor.

17. Coordination of Benefits for Dual Eligible Members

a. The MCO is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. The MCO must ensure that services covered and provided under this contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The MCO must coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. The MCO must propose strategies, in its RFP response, to coordinate care for dually-eligible members.

b. The MCO must sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. Under this crossover process, a Medicare provider, who may or may not be part of the MCO's network, must submit a claim to Medicare and there is an automatic crossover to MLTC for whatever Medicaid payment is due.

c. The MCO must include in all of its provider agreements provisions to ensure continuation of benefits. In addition, the provider agreement must specify the provider's responsibility regarding TPL, including:

i. Identifying TPL coverage, including Medicare and long-term care insurance as applicable.

ii. Seeking TPL payments before submitting claims to the MCO.

T. REPORTING AND DELIVERABLES

1. General Requirements

a. This section of the RFP describes in general terms the requirements placed on the MCO regarding State and Federal reporting. Program and financial reporting requirements are discussed throughout the RFP and summarized in Attachment 6 – Reporting Requirements. The MCO must comply with all reporting requirements, or to the extent it does not it may be subject to penalties, sanctions, or contract termination.

b. All deliverables are subject to review by the State and will not be considered complete until deemed complete by MLTC. The format and content of each deliverable must be defined and

agreed upon prior to the onset of work. The State will not review a deliverable unless the format and content has been approved in advance.

c. MLTC may grant approval, reject all or some part of the deliverable, or request that revisions be made by the MCO. Additional review periods are required whenever revisions are requested or a deliverable is rejected. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the MCO to revise deliverables previously approved or to reject current deliverables based on inconsistencies with previously approved deliverables.

d. MCO policies are subject to approval by MLTC, and will be monitored through operational reviews.

2. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The MCO must disclose this information to MLTC with its proposal. This information must be provided during the readiness review, annually thereafter for each contract year, and within 30 calendar days of any change in the MCO's management, ownership or control.

3. Information Related to Business Transactions

a. The MCO must furnish, to MLTC and the federal DHHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this contract.

b. The MCO must submit, within 30 calendar days of a request made by MLTC, full and complete information regarding:

i. The ownership of any subcontractor with whom/which the MCO has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

ii. Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of the request.

c. For the purpose of this contract, "significant business transactions" means any business transaction or series of transactions during any State fiscal year that exceed(s) $25,000 or 5% of the MCO's total operating expenses, whichever is greater.

4. Encounter Data

a. The MCO must comply with the required format and timelines provided by MLTC for the submission of encounter data. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to members through the MCO during a specified reporting period. MLTC collects and uses this data for many purposes such as federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement, utilization patterns, access to care determinations, and various research studies.

b. MLTC may change the encounter data transaction requirements with 90 calendar days advance written notice to the MCO. The MCO must, on notice from MLTC, make the necessary changes to its systems to comply with MLTC requirements and provide notice of the changes to its contractors. It is the MCO's responsibility to ensure that its contractors comply with MLTC requirements within the specified timeframes.

5. Financial Reporting

a. The MCO must submit quarterly and annual financial reporting to MLTC. The details and timing of the reports will be developed with MCO input. Examples of expected reports include, but are not limited to:

i. Certification statement.

ii. Balance sheet.

iii. Income statement.

iv. Lag (incurred but not reported) report.

v. Medical loss ratio calculation.

vi. Profit/risk corridor calculation report.

vii. Related-party statements.

viii. Run rate income statement.

ix. Auditor's report and report on internal controls.

x. Performance measure calculation reports.

xi. Annual disclosure report.

xii. Enrollment/revenue reconciliation.

b. MLTC also requires the MCO to electronically provide detailed claims and membership data that tie to the run rate income statement. The MCO's response to a MLTC data request shall include, at a minimum, the following data fields:

i. Rating category.

ii. Category of service.

iii. Utilizers.

iv. Paid dollars.

v. Paid units.

vi. Units measure.

vii. Paid days.

viii. Cost per unit.

ix. Cost per day.

x. Per member per month (PMPM) cost.

xi. Member months.

xii. Month of service.

xiii. Month of payment.

c. The MCO must obtain an annual financial audit acceptable to MLTC for any expenditure of State-awarded funds made by the MCO. The audit must include management letters and audit recommendations.

d. State auditors must have access to all records and accounts for the contract year(s) in which the award was made. The MCO must comply with Federal and State single audit standards, as applicable. MLTC reserves the right to audit or request an audit (at the MCO's expense) of any data or report required under the contract.

e. Risk contracts must provide that MLTC and CMS may inspect and audit any financial records of the MCO or its contractors. There must be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits either of them deem necessary to assure quality, appropriateness, or timeliness of services and reasonableness of their costs.

6. Information on Persons Convicted of Crimes

The MCO must furnish to MLTC information about any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to comply with this requirement may lead to termination of this contract.

7. Submission Process and Timeframes

a. The MCO must ensure that all required deliverables, which may include documents, manuals, files, plans, or reports, as stated in this RFP or required at a future date, are submitted to MLTC in a timely manner for review and approval. The MCO's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in Section IV.V Contract Non-Compliance of this RFP.

b. MLTC may, at its discretion, require the MCO to submit additional deliverables both ad hoc and recurring. If MLTC requests any revisions to the deliverables already submitted, the MCO must make the changes and re-submit the deliverables, according to the time period and format required by MLTC. A 60 calendar day notice will be given on changes to any ongoing reports.

c. Unless otherwise specified in Attachment 6 – Reporting Requirements, deadlines for submitting deliverables are:

i. Monthly deliverables must be submitted no later than the 15th calendar day of the following month.

ii. Quarterly deliverables must be submitted within 45 calendar days of the last day of the calendar quarter immediately preceding the due date.

iii. Annual reports and files, and other deliverables due annually, must be submitted within 30 calendar days following the 12th month of the contract year; except, those annual reports that are specifically exempted from this 30 calendar day deadline by this RFP or by written agreement between MLTC and the MCO.

iv. If a due date falls on a weekend or State-recognized holiday, deliverables are due the next business day.

8. Ad Hoc Reports

a. The MCO must prepare and submit any other reports required and requested by MLTC, any of MLTC's designees, the State Legislature, or CMS that are related to the MCO's duties and obligations under this contract. Information considered to be proprietary must be clearly identified by the MCO at the time of submission.

b. Ad-hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

9. Errors

a. The MCO must prepare complete and accurate reports for submission to MLTC. If after preparation and submission, a MCO error is discovered, either by the MCO or MLTC, the MCO must correct the error(s) and resubmit the report within the following timeframes:

i. For encounters, in accordance with the timeframes specified in the Section IV.S Claims Management of this RFP.

ii. For all reports, 15 calendar days from the date of discovery by the MCO or date of written notification by MLTC (whichever is earlier). MLTC may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can

demonstrate to MLTC's satisfaction that the problem cannot be corrected in 15 calendar days.

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

10. Reporting Dashboard

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

i. Member enrollment.

ii. Call center statistics.

iii. Status of credentialing applications.

iv. Performance measures.

v. Care management.

vi. Pending grievances and appeals.

vii. Pending claims.

viii. Financial status.

ix. Any other issues as identified by MLTC.

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

U. CONTRACT MONITORING

1. MCO Policies and Procedures

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

2. Operational Reviews

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

b. This monitoring by MLTC does not relieve the MCO of its responsibility to continuously monitor its providers' and subcontractors' performance to ensure compliance with contract provisions.

c. Except in cases in which advance notice is not possible or advance notice may render the review less useful, MLTC will give the MCO a minimum of three (3) weeks advance notice of the date of

a review. MLTC reserves the right to conduct reviews without notice to monitor contractual requirements and performance.

d. MLTC, or its designee, will coordinate with the MCO to establish the scope of any review, the review site (if on-site), relevant time frames for obtaining information, and the review criteria.

e. MLTC may request, at the expense of the MCO, to conduct on-site reviews of functions performed at out-of-State locations and will coordinate travel arrangements and accommodations with the MCO.

f. The review may include an inspection of the MCO's facilities, as well as auditing or review of any records including, but not limited to, medical records, grievances, enrollments, disenrollments, utilization and medical management, finance, management systems, policies and procedures, or any other areas or materials relevant to this contract.

g. In preparation for a review, the MCO must cooperate with MLTC, by forwarding, in advance, policies, procedures, job descriptions, contracts, records, logs, and any other materials upon request. Documents not requested in advance must be made available during the course of a review. MCO staff must be available at all times during a review. The MCO must provide an appropriate private workspace and internet access to the review team.

h. The MCO will be provided a copy of the draft review report and given the opportunity to comment on any review finding prior to MLTC issuing the final report, unless the review concerns potential fraudulent or criminal action. The MCO must develop corrective action plans based on the recommendations, if necessary. However, once MLTC finalizes the findings, the MCO must comply with all recommendations that result from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions, and/or enrollment restrictions.

i. Corrective action plans and any modifications must meet the approval of MLTC. Unannounced follow-up reviews may be conducted at any time after the initial operational review, to determine the MCO’s progress in implementing the recommendations and achieving compliance.

j. The MCO may not distribute, or otherwise make available, the operational review tool, draft operational review report, or final report to other MCOs.

3. Business Reviews

a. MLTC will schedule business reviews with each MCO, which will be held on a quarterly basis or frequency as determined by MLTC. Business reviews are regular meetings with MLTC staff and MLTC leadership to review ongoing business operations of the MCO, performance metrics, quality outcomes, and other topics as determined by MLTC.

b. The MCO shall participate in MLTC-organized business reviews.

c. The MCO CEO will participate in, and ensure other key staff members as requested by MLTC to participate in the business reviews. The CEO must ensure the MCO is prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

V. CONTRACT NON-COMPLIANCE

1. Administrative Actions

a. In the event the MCO fails to perform any obligation under the contract, at the discretion of MLTC, the MCO may be subject to the administrative actions detailed below. , MLTC will provide written notice to the MCO of non-compliance or deficiency. Administrative actions exclude liquidated damages, intermediate sanctions, and termination, and include:

i. A warning through written notice (may include consultation).

ii. Education about program policies and billing procedures. The MCO may be required to participate in a provider education program as a condition of continued participation.

MCO education programs may include attendance at quarterly meetings, at which issues and topics may include, but not be limited to:

a) The use of procedure codes.

b) The review of key provisions of the Medicaid program.

c) Instruction about reimbursement rates.

d) Instruction about how to inquire about coding problems.

e) Quality/medical issues.

iii. Submission of a Corrective Action Plan (CAP). MLTC will approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, and required status reports.. The CAP must address:

a) The steps to be taken by the MCO to comply with the terms of the contract.

b) A timeframe for anticipated compliance and a date certain for correction of the issue.

2. Liquidated Damages

MLTC may impose liquidated damages if the terms of the CAP are not met. Liquidated damages will continue until satisfactory correction of the issue has occurred, as determined by MLTC.

In the event the MCO fails to comply with any term or condition of the RFP or specifically subparagraphs a – h as listed below, the damages detailed in this section and Attachment 18 – Liquidated Damages may be assessed in the sole discretion of MLTC. If assessed, the damages will be used to reduce MLTC's payments to the MCO. If the damages exceed amounts due from MLTC, the MCO will be required to make cash payment to MLTC for the amount in excess.

a. Readiness Review

MLTC will conduct a formal review of the MCO's readiness to implement all required services described in this RFP. Should the MCO fail the review, MLTC may assess damages of $5,000 for each calendar day until such time as MLTC certifies that the MCO has met all readiness requirements.

b. Date of Implementation

Should the MCO fail to begin full operations on the contract start date, and should MLTC determine that the MCO is responsible for the delay, MLTC may assess damages of $10,000 per calendar day for each day beyond the contract start date that the MCO fails to begin full operations.

c. Timely Reports and Data Delivery Requirements

All reports and data (including encounters) required by the contract must be produced in the format and media approved by MLTC and submitted by the due dates required by MLTC. If the data is incomplete, incorrect, or untimely, MLTC may assess a penalty of $1,000 for each calendar day that a report or data delivery is late, includes less than the required copies, or is not in the approved format.

d. Network Performance Requirement

Between the contract award date and the contract start date, the MCO must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of 90 calendar days prior to the contract start date. MLTC may assess a penalty of $1,000, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.

e. Employment of Key Personnel

The MCO must meet all key personnel requirements specified in Section IV.D Staffing Requirements of this RFP. MLTC may assess a penalty of $1,000 per day, per position, for each day after the 30 allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.

f. Excessive Reversals on State Fair Hearings

If more than 10% of the MCO decisions on member appeal are overturned by the State Fair Hearing process the MCO may be assessed a penalty of $25,000 per reversal exceeding 10% in a contract year.

g. Marketing and Member Education Violations

i. Whenever MLTC in its discretion determines the MCO or any of its agents, subcontractors, volunteers, or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, or providing any health care services, in the discretion of MLTC one or more of the remedial actions specified in Section IV.V Contract Non-Compliance shall apply.

ii. Unfair, deceptive, or prohibited marketing practices shall include, but are not limited to:

a) Failing to secure written approval before distributing marketing or member materials.

b) Engaging in, encouraging, or facilitating prohibited marketing by a provider.

c) Directly marketing to members or potential members.

d) Failing to meet time requirements for communication with new members (e.g., distribution of welcome packets or welcome calls).

e) Failing to provide interpretation services or make materials available in required languages.

f) Engaging in any of the prohibited marketing or member education practices detailed in this RFP.

g) Making false or misleading verbal or written statements, visual descriptions, advertisements, or other representations of any kind that have the capacity, tendency, or effect of deceiving or misleading MCO members or potential members about any health care services, the MCO, any health care provider, or the HERITAGE HEALTH.

h) Representing that a MCO or network provider offers any service, benefit, access to care, or choice that it does not offer.

i) Representing that a MCO or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure that it does not possess.

j) Failing to state a material fact, if the failure deceives or tends to deceive.

k) Offering any kickback, bribe, award, or benefit to any Medicaid enrollee as an inducement to select, or to refrain from selecting, any health care service, MCO, or health care provider.

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

1) Medical records information.

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

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

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

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

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

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

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

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

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

3. Failure to Provide Benefits and Services

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

W. INTERMEDIATE SANCTIONS

1. Acts or Failures to Act Subject to Intermediate Sanctions

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

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

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

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

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

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

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

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

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

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

2. Other Misconduct Subject to Intermediate Sanctions

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

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

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

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

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

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

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

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

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

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

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

3. Sanction Types

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

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

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

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

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

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

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

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

4. Notice of Sanction to MCO and CMS

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

i. The basis and nature of the sanction.

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

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

5. Payment of Liquidated Damages and Sanctions

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

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

i. The duration of the violation.

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

ii. The MCO's compliance history.

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

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

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

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

6. Special Rules for Temporary Management

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

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

provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

7. Payment of Outstanding Monies or Collections from MCO

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

8. Provider Sanctions

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

X. TRANSITION AND IMPLEMENTATION

1. Preliminary Implementation Plan

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

i. Member services.

ii. Network development and management.

iii. Quality management, including credentialing.

iv. Care management.

v. Utilization management.

vi. Transition and care coordination.

vii. Information systems management.

viii. Claims management.

ix. Grievances and appeals.

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

2. Transition Period

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

b. On contract award, the MCO must immediately begin collaborating with MLTC to review the contract, its proposal, and preliminary implementation plan. The MCO must provide to MLTC implementation plan updates, weekly, and collaborate with MLTC to address the following:

i. Defining project management and reporting standards.

ii. Establishing communication protocols between the MCO, MLTC, and existing providers.

iii. Defining expectations for the content and format of contract deliverables.

iv. Resolving transition and implementation issues to MLTC's satisfaction.

c. At minimum, the MCO must have the following key staff in place to participate in the transition coordination/collaboration process:

i. Chief Executive Officer.

ii. Chief Operating Officer.

iii. Medical Director/Chief Medical Officer.

iv. Behavioral Health Clinical Director.

v. Member Services Manager.

vi. Provider Services Manager.

vii. Information Management and Systems Director.

viii. Quality Management Coordinator.

ix. Case Management Administrator.

3. Comprehensive Implementation Plan

a. After contract award and before contract start date, the MCO must develop a detailed and comprehensive implementation plan to monitor progress throughout the transition/implementation period.

b. The MCO must include in its implementation plan a detailed description of its implementation tasks, methods, staff accountable for completing tasks, and timelines, at a minimum for the following areas/issues:

i. Staffing.

ii. Data systems including system readiness testing, acceptance testing, transfer of electronic data and records, and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data.

iii. Network development.

iv. Clinical transition.

v. Utilization management.

vi. Care management.

vii. Quality management.

viii. Member services.

ix. Member outreach/communications.

x. Security, business continuity, disaster recovery, and contingency planning.

xi. Member Handbook and Provider Manual completion.

xii. Claims and eligibility interface development.

xiii. Compliance plan.

xiv. Financial reporting plan.

xv. Member and staff orientation and training plans.

xvi. Post-implementation deliverables.

4. Network Adequacy Requirement

The MCO must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population 90 calendar days prior to the contract's start date. The MCO must submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract effective date. The plan must detail the MCO's network, including GeoAccess reports, and describe any provider network gaps and the MCO's remediation plans. Additional requirements regarding network adequacy are included in Section IV. I Provider Network Requirements of this RFP.

5. Personnel

The MCO must submit key staff resumes with its proposal, as possible. All key staff, as detailed in Section IV.D Staffing Requirements must be hired prior to the Readiness Review. A minimum of two (2) weeks prior to the readiness review, the MCO must submit to MLTC the resumes of any key staff member (that was not submitted with the MCO's proposal) for MLTC review and approval. At that time, the MCO must submit updated organizational charts. The MCO must have sufficient personnel working and operating in the State during the transition and implementation period in order to be fully compliant with the terms of the contract.

6. Transitioning of Managed Care Members and Operations

a. When applicable, the MCO must transition members receiving services so care is not disrupted.

b. The MCO must collaborate with the current MCOs, the behavioral health MCO, the Pharmacy Benefits Manager, and providers to develop and implement care plans for members who require them during the transition and deliver all services contained in the plans.

c. At a minimum, the MCO must provide service information, emergency telephone numbers, and instructions about how to obtain additional services to each member affected by the transition.

d. If applicable and as necessary, the MCO must transition from the current MCO to the new MCO, pending grievances, appeals, and member/provider service issues to ensure their timely resolution.

e. The MCO must have a sufficient number of qualified staff to meet filing deadlines and attend all court or administrative proceedings.

7. Transitioning from the MLTC FFS Pharmacy Program to the MCO Pharmacy Program

a. The MCO must submit a transition plan to MLTC for review and approval prior to the start date of operations that includes, at a minimum, procedures for continuity of care of prior authorized pharmacy services when an individual transfers from the MLTC FFS pharmacy benefit to the MCO pharmacy plan. This transition plan must ensure that members can continue treatment with any prescribed medications for a period of a minimum of 90 calendar days.

b. The MCO must load to its pharmacy claims processing system the current prior authorization records from MLTC or its designee prior to the contract start date. The MCO is responsible for creating drug reference file conversion tables if needed. The MCO must also load the current restricted services designation(s) by the MLTC FFS pharmacy program to its system prior to the contract start date.

8. Readiness Review

a. Prior to the contract start date, MLTC will conduct an operational and financial readiness review of the MCO, and will provide needed technical assistance. The MCO must cooperate with MLTC's review process to assess the MCO's operational readiness and ability to provide covered services to members as of the contract start date. The MCO will be permitted to commence operations, and Medicaid enrollees will be enrolled with the MCO, only if the readiness review factors are met to MLTC's satisfaction.

b. Based on the results of the review, MLTC will issue a letter of findings and, if necessary, request a corrective action plan from the MCO.

c. The readiness review will cover all provisions of the contract with a particular focus on assessing the following areas:

i. Network adequacy.

ii. Staffing adequacy.

iii. Subcontracts.

iv. Provider services.

v. Member services.

vi. Quality management.

vii. Care management.

viii. Utilization management.

ix. Financial management.

x. Information processing and system testing.

xi. Transition of behavioral health recipients.

xii. Continuity of care.

xiii. Grievance and appeal process.

d. During the readiness review, the MCO must provide to MLTC staff access to MCO staff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

e. If the MCO is unable to demonstrate its ability to meet the requirements of this contract, as determined by MLTC, within the time frames specified by MLTC, MLTC may terminate this contract and have no liability for payment to the MCO.

Y. Termination of MCO Contract

a. In the event a MCO is terminated or its contract expires, the MCO must provide services through the end of the contract term and pay for all covered services for all members prior to the date of contract termination.

b. The MCO must submit, for approval by MLTC, a detailed plan for the transition of its members to another MCO that includes the schedule for key activities and milestones. The MCO must:

i. Make provisions for continuing all management and administrative services and the delivery of direct services to members until the transition of all members is completed and all other requirements of the current contract are satisfied.

ii. Designate a person with the appropriate training to act as the transition coordinator. The transition coordinator must interact closely with MLTC and staff from the other MCO to ensure a safe and orderly transition.

iii. Provide all reports set forth in this contract necessary for the transition process. This includes providing MLTC, until MLTC is satisfied that the MCO has completed all outstanding obligations, the following additional reports. These reports are due on the fifth day of each succeeding month for the prior month:

iv. Monthly claims aging report by provider/creditor including incurred-but-not-reported amounts.

v. Monthly summary of cash disbursements.

vi. List of all outstanding obligations necessary to complete the contract.

vii. Notify subcontractors of contract termination or expiration, as directed by MLTC.

viii. Notify all its members that the MCO will no longer serve as their MCO a minimum of 45 calendar days in advance of the termination. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

ix. Notify each participating provider in writing that the MCO's contract with MLTC is ending a minimum of 45 calendar days in advance of the termination. The written notice must include the contract end date and must explain to the participating provider how the provider can continue participating in the Medicaid program. The MCO shall be financially responsible for all costs associated with this notification. The notification must be approved in advance by MLTC.

x. Pay all outstanding obligations for covered services provided to members. The MCO must cover continuation of services for members for the period for which payment is made, as well as for inpatient admissions up until the member's discharge.

xi. Cooperate with other MCOs during the transition period including, at a minimum, sharing and transferring member information and records. MLTC will notify the MCO with specific instructions and about required actions at the time of transfer.

xii. Return any funds advanced to the MCO for coverage of members for periods after the contract end date to MLTC within 30 calendar days of the contract end date.

xiii. Supply all information necessary for reimbursement of outstanding claims.

xiv. Provide MLTC, in a format approved by MLTC:

a) A list of all network providers.

b) A list of members who are receiving care management services.

c) A list of all services requiring MCO prior authorization.

d) A list of all members receiving prior authorized services with an approved duration that extends beyond the contract termination date.

Z. FFS CLAIMS MANAGEMENT AND PROCESSING

The State of Nebraska intends to award a minimum of two (2) and a maximum of three (3) MCO contracts for the scope of work as described in Section IV. A. Program Description through Y. Termination of MCO Contract. One of the awarded contracts will also include the scope of work as described in Section IV. Z. FFS Claims Management and Processing.

1. Claims Broker Services

The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with a MCO.

In addition to the MCO responsibilities outlined in this RFP, MLTC will award the processing of the remaining Nebraska Medicaid FFS claims, hereafter referred to as "claims broker services," to a single MCO. Any reference to claims in this section is also inclusive of FFS adjustments, recoupments, voids, and financial transactions. Payment for claims broker services will be paid separately from managed care capitation payments. MLTC will pay the claims broker an administrative processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate.

MLTC will reimburse the MCO for claims broker services based on a per claim administrative fee. The fee will be adjusted yearly based on administrative expense for the FFS claims processing. Each year, the CBS will report the PMPM costs for FFS claims by the following categories:

1. Provider Services
2. Care Coordination / Service Authorizations
3. Member Customer Services
4. Data Capture
5. Claim / Adjustment Processing and Adjudication
6. TPL/COB
7. Grievance and Appeals

All values in red below indicate a value that must be submitted by the CBS.

Category	**Populations not covered by Managed Care 2.0 - All Services**
Provider Services	(1)
Care Coordination / Service Authorizations	(2)
Member Customer Services	(3)
Data Capture	(4)
Claim / Adjustment Processing and Adjudication	(5)
TPL/COB	(6)
Grievance/Appeals	(7)
Total	**(1)+(2)+(3)+(4)+(5)+(6)+(7) = (8)**
MMs	**(9)**
Annual Dollar Est.	**(8) * (9) = (10)**

The State will use the reported values to calculate an updated total dollar estimate by taking the total PMPM for each population and multiplying it by the corresponding MMs (as illustrated by (10), in the above table). This annual dollar estimate will be divided by the fee-for-service claim volume for each year to determine the administrative price per claim for the next year.

MLTC will pay for a claim to be processed multiple times if the resubmission is due to provider error. If a claim is denied multiple times due to a claims broker error, MLTC will only pay to process the claim once.

The claims broker must provide detailed reports to the State for validation of FFS payments and recoveries. The claims broker is responsible for all servicing aspects of FFS claims unless otherwise expressly identified as an exception by MLTC. MLTC will award the claims broker services portion of this contract to the winning MCO with the highest score for Section IV. R. Systems and Technical Requirements, S. Claims Management and Z. FFS Claims management and Processing.

The MCO chosen as the claims broker must develop and maintain claims handling and payment policies and procedures in accordance with Nebraska Medicaid policy, CMS's National Correct Coding Initiative (NCCI) guidelines and Medicaid service limits. The claims broker must ensure accurate collection, processing, payment, and reporting of all FFS claims.

2. Reimbursement for Claims Broker FFS Payments

The claims broker must make payments for all FFS claims to providers. The claims broker must submit to MLTC a reconciliation report of all funds expended and received with remaining balance to be reimbursed for FFS payments. The claims broker may submit a funding request on a weekly basis to MLTC to cover the cost of FFS claims payments. The report must be submitted with each funding request to justify the request.

3. Implementation Timeframe

MLTC anticipates that the implementation of the claims broker functionality will occur during the second year of the contract. MLTC will identify the date for claims broker services to begin and MLTC will coordinate with the MCO providing the claims broker services throughout years one (1) and two (2) of the contract.. The claims broker must submit to MLTC with its proposal the number of months that it will take to be ready to pay FFS claims. MLTC will give the claims broker sufficient time to ensure a smooth implementation process.

4. Functionality

The claims broker must maintain the same functionality for FFS claims that is required for managed care claims as described in Section IV.S Claims Management of this RFP. FFS claims must be processed even if the billing provider is not contracted with the MCO who is performing claims broker services. The claims broker processing system must handle retroactive member eligibility and process claims accordingly.

The MCO must make system or operational changes for FFS claims processing within 60 calendar days of notification by MLTC. The claims broker must correct all processing errors identified by MLTC immediately on notification. Recoupment of erroneous payments made to providers is the sole responsibility of the claims broker. MLTC will not reimburse the claims broker for uncollected recoupments for claims paid in error.

The claims broker processing system must maintain functionality to process claims for services that require unique provider and member reimbursement methodologies that differ from standard processing protocol.

The claims broker must give MLTC inquiry access to its FFS claims processing system to view claims and all information related to FFS claims processing. The claims broker must provide system user training to MLTC staff who support this scope of work.

5. Claims Processing

The claims broker must maintain the same claims processing standards for all non-drug FFS claims that is required for managed care claims, as described in Section IV.S Claims Management of this RFP. Requirements for rejected claims, pended claims, adjustments, voids, and timely filing guidelines must mirror managed care requirements. Claim system edits for FFS claims must be maintained in the same manner as required for managed care claims. The claims broker should expect that FFS claims will have different editing and payment methodologies than managed care claims, and must maintain these edits and payment processes separately. The claims broker claims processing system must post all applicable edits to denied FFS claims during a single processing cycle.

6. Drug Claims Processing

The claims broker must use a PBM to process all FFS drug claims. The PBM must pay FFS claims in accordance with the same requirements for managed care pharmacy claims in this RFP.

7. Service Authorization Procedures

The claims broker must develop and administer prior authorization procedures for services paid as FFS in accordance with Nebraska Medicaid policy and the requirements of Section IV.N Utilization Management of this RFP. FFS claims must be paid or denied in accordance with FFS authorization policies.

8. Payments to Providers

The claims broker must pay FFS claims at a fee schedule rates set by MLTC.

9. Remittance Advice

The claims broker must adhere to the same remittance requirements for FFS claims as required for managed care claims as outlined in Section IV.S Claims Management of this RFP.

10. Third Party Liability

The claims broker must develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for FFS members. Information regarding TPL must be maintained on the member file and utilized during claims payment to ensure that Medicaid is the payer of last resort. The claims broker will also perform recovery activities for claims that have been paid by Medicaid where third-party coverage was applicable. These payment recoveries will be returned to the State in full immediately upon receipt. The claims broker must expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS claims as is expended on managed care claims. Denial of FFS claims for TPL coverage must comply with all MLTC policies and applicable law. MLTC will retain responsibility for all estate recovery activities.

11. Member Services

The claims broker must provide member services call center activities to all eligible FFS members in the same manner as required for managed care members as outlined in Section IV.F Member Services and Education of this RFP. MLTC will provide the claims broker with an interface that provides FFS member eligibility.

12. Provider Services

The claims broker must provide a provider toll-free telephone line to all providers who render services to FFS members, according to the requirements of Section IV.J Provider Services of this RFP. These services must be available to providers even if they are not contracted with the MCO providing claims broker services. These activities include the management of electronic data interchange and trading partner agreements, as well as call center support for provider inquiries such as member eligibility and benefit limits, claims processing issues, or other program clarifications. The claims broker must make provider notifications, bulletins, newsletters, FAQs and other pertinent information available on its website to providers participating in the FFS programs.

13. Paid Claims Sampling

The claims broker must adhere to the same paid claims sampling requirements for FFS claims as required for managed care claims outlined in Section IV.S Claims Management of this RFP.

14. Claims Dispute Management

The claims broker must adhere to the same claims dispute management requirements for FFS claims as required for managed care claims outlined in Section IV.S Claims Management of this RFP. FFS claims must be disputed through the State fair hearing process. The claims broker must support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

15. Claims Payment Accuracy

The claims broker must adhere to the same claims payment accuracy requirements for FFS claims as required for managed care claims as outlined in Section IV.S Claims Management of this RFP.

16. Claims Data

The claims broker must submit all data relevant to the adjudication and payment of FFS claims to MLTC as required by the State. All claims data must be submitted to MLTC in standard HIPAA formats, as applicable. FFS claims data (including adjustments and recoupments) must be submitted a minimum of monthly on a date designated by MLTC. Claim data must be identified as FFS and must have the appropriate account code on the claim.

17. Drug Rebates

The claims broker must provide pharmacy claims information to MLTC so the State may perform all drug rebate activities (including disputed drug rebates) for FFS drug claims.

18. Audit Requirements

The claims broker must adhere to all audit requirements for managing FFS claims as required for managed care claims, as outlined in Section IV.S Claims Management of this RFP. The claims broker must support MLTC by providing claims payment explanations, as requested.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

Further, Section III. Terms and Conditions must be returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal must consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder must provide three years of independently audited financial statements, prepared under U.S. generally accepted accounting principles, and associated enrollment figures applicable to the firm. The bidder must also provide the last three years rating from AM Best Company; verification of any contributions made to the bidder to improve its financial position after its most recent audit (e.g. copies of bank statements and deposit slips), if applicable; and, a statement of whether the bidder or predecessor company has filed or had filed against it any bankruptcy or insolvency proceeding, and if so, relevant details. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization in the form of a letter, indicating that the bidder's business relationship with the financial institution is in positive standing.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Sub-Contractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Sub-Contractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description shall identify whether the work was performed as the prime Contractor or as a Sub-Contractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Sub-Contractor(s) experience must be listed separately. Narrative descriptions submitted for Sub-Contractors must be specifically identified as Sub-Contractor projects.

iii. If the work was performed as a Sub-Contractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Sub-Contractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Sub-Contractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and a minimum of three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUB-CONTRACTORS

If the bidder intends to Sub-Contract any part of its performance hereunder, the bidder must provide:

vi. name, address, and telephone number of the Subcontractor(s);
vii. specific tasks for each Subcontractor(s);
viii. percentage of performance hours intended for each Subcontract; and
ix. total percentage of Subcontractor(s) performance hours.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

a. Understanding of the project requirements (limited to three pages);
b. Response to proposal statements and questions in Attachment 19 – Proposal Statements and Questions; and
c. Proposal deliverables as listed in Attachment 5 – Policies, Procedures, and Plans.

Form A
Bidder Contact Sheet
Request for Proposal Number 5151 Z1

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

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

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

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Form B

Notification of Intent to Attend First Pre-Proposal Conference

Request for Proposal Number 5151 Z1

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Fax Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivered or US Mail by the date shown in the Schedule of Events.

NEBRASKA
AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

Pre-Solicitation Notice and Schedule of Events for Medicaid Integrated Managed Care Procurement

TO: All Prospective Bidders

FROM: Michelle Thompson / Teresa Fleming

DATE: October 19, 2015

SUBJECT: RFP Number 5151Z1 for Statewide Medicaid Integrated Managed Care Contracts

The State of Nebraska, Department of Health and Human Services (DHHS), is issuing notice of its intent to release a Request for Proposal, RFP Number 5151Z1, for the purpose of selecting qualified contractors to provide statewide integrated medical, behavioral health, and pharmacy services for approximately 230,000 Medicaid and Children's Health Insurance Program (CHIP) enrollees through the Medicaid managed care delivery system. DHHS expects to award a minimum of two or a maximum of three contracts for the program in March 2016 and the program to begin operations on January 1, 2017.

A planned schedule of events for this procurement is included below in this notice. The RFP will be available and posted to the Internet prior to the date of the first pre-proposal conference (October 26, 2015). At the pre-proposal conference, leadership from the Division of Medicaid and Long-Term Care will present an overview of the scope of the RFP and planned changes to the managed care program. The state will also have its contracted actuarial firm Optumas available to provide an overview of the capitation rate assumptions and methodologies.

Notification of release of the RFP will be sent to those included in the contact list for this notice. To be added to this list, interested parties should notify Michelle Thompson / Teresa Fleming at as.materielpurchasing@nebraska.gov.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	TBD
2.	Last day to submit "Notification of Intent to Attend Pre-Proposal Conference"	October 23, 2015
3.	First Pre-Proposal Conference Location: Nebraska State Office Building 301 Centennial Mall South Lower Level, Conference Room A Lincoln, NE 68508 Call-in information for those unable to be present is as follows: Conference Access Number: (888) 820-1398 Attendee Code: 8559164#	October 26, 2015 1:00 – 5:00 PM Central Time
4.	Last day to submit First Round of written questions	November 2, 2015
5.	State responds to First Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 16, 2015
6.	Second Pre-Proposal Conference (if needed) Location: Lincoln, NE *Room and specific time to be announced at a later date. This will be held at the option of the state.*	November 19, 2015
7.	Last day to submit Second Round written questions	November 23, 2015
8.	State responds to Second Round of written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 7, 2015
9.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 22, 2015 2:00 PM Central Time

A more complete schedule of events, including planned activities after proposal opening, will be included in the RFP at its release